PRINTED: 10/21/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297107	B. WING			
	OVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	<u> 09/1</u>	8/2009
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS	;	G 00	00		
	a result of the Medica conducted at your ag CFR Part 484 - Home September 10, 2009 2009.	ficiencies was generated as are re-certification survey, ency in accordance with 42 e Health Services from through September 18,				
		ecords were reviewed, d records. Five home visits				
	by the Health Divisior prohibiting any crimin actions or other claim	clusions of any investigation in shall not be construed as al or civil investigations, as for relief that may be under applicable federal,				
		maintain condition level ollowing Conditions of				
	42 CFR 484.30 - Skill	oorting OASIS Information led Nursing Services nprehensive Assessment of				
G 121	The following regulate identified: 484.12(c) COMPLIAN PROFESSIONAL ST	NCE W/ ACCEPTED	G 12	21		
	professional standard	f must comply with accepted Is and principles that apply shing services in an HHA.				
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	1G		09/18	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•	e	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	•	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
G 121	Continued From page	e 1	G	121			
	This STANDARD is Surveyor: 25418	not met as evidenced by:					
	review, the agency fa compliant with accept	n, interview and document iled to ensure staff were ted professional standards earing for 2 of 4 patients 2, 3).					
	Findings include:						
	Patient #2						
	Patient #2 was admit moderately sized low wound.	ted on 9/11/09 with a er abdominal surgical					
	after Patient #2 had s documents, the skille hands. The SN got the stethoscope out of he proceeded to use the	equipment. The SN put the her nursing bag without					
	The SN checked Pati temperature. The SN into the nursing bag vequipment and performance.	I put the thermometer back without cleaning the					
	Patient #2's wound at The SN did not perform	n, removed the packing from nd then, removed the gloves. rm hand hygiene prior to sing bag and retrieving a					
	The SN put gloves or	n and used a long cotton					

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		297107	B. WIN	IG	 	09/1	8/2009
	ROVIDER OR SUPPLIER	LTH CARE INC	•	6	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 121	Patient #2's wound. and proceeded to ope without having perfor The SN performed ha into bag to obtain a m put on gloves and me size. The SN remove hand into the bag with hygiene. The nurse then open used an alcohol pad without gloves on. N gloves and loosely pa The SN removed the dressing with tape. T after the gloves were The SN placed her fla without cleaning the fla without cleaning the fla hand hygiene. Patient #3 Patient #3 Patient #3 Patient #3 was admit diagnoses including p heel, aftercare for a fi insulin dependent dia On 9/11/09 in the after Patient #3's home, th pressure ulcer, and re then put on a new pa performing hand hygi the wound.	theck for additional packing in The SN removed the gloves en the gauze pad packages med hand hygiene. and hygiene and put hand heasuring device. The SN easured Patient #2's wound ed the gloves and placed her hout performing hand ed gauze packages and to clean a pair of scissors ext, the SN put on new acked Patient #2's wound. gloves and secured the There was no hand hygiene removed. ashlight back into the bag dashlight and performing ted on 6/15/09 with pressure ulcer of the right ractured tibia/fibula and abetes mellitus. ernoon during a visit to e SN cleansed the right heel emoved her gloves. The SN	G	121			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297107	B. WIN	G		09/18/2009	
	ROVIDER OR SUPPLIER NS CHOICE HOME HEAD	LTH CARE INC	•	60	EET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014	00/1	5/2000
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 121	pressure cuff. The SN cleaned her sand stethoscope with placed the equipment without first performint. On 9/18/09 in the after the SN should be was glove changes. According to the ager Hand Washing reveal indicated " 3. d. Bet client, and; 3. f. After. The agency's undated Precautions for All He indicated " 3. Glove medical gloves, must reusable equipment.	de the bag for the blood scissors, blood pressure cuff out gloves on. The SN t inside the her nursing bag ag hand hygiene. ernoon, the DPS confirmed shing their hands between acy's undated policy, D-330 led "Hand washing is sween tasks on the same removing gloves" d policy, D-245 Standard ealth Care Workers, es such as vinyl or latex be worn when cleaning"		121			
	under paragraph (d) of qualified personnel are education and evaluation. This STANDARD is a Surveyor: 25418 Based on record reviewinterview, the Administration of the paragraph (d) or paragrap	or registered nurse required of this section, employs and ensures adequate staff tions. not met as evidenced by: ew, document review and strator failed to ensure evaluations were completed					

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		297107	B. WIN	G		09/1	8/2009
	NS CHOICE HOME HEA	LTH CARE INC	•	6	REET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 IENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 134	registered nurse to poor of Director of Profess The personnel file for	ed in January, 2004 as a erform patient care visits. e #2 accepted the position ional Services (DPS). Employee #2 lacked e of an annual performance	G	134			
G 143	Performance Evaluati performance evaluati employees after one at least annually them. On 9/18/09 in the mo acknowledged annua were not done for all 484.14(g) COORDIN SERVICES All personnel furnishi to ensure that their eleffectively and support the plan of care.	rning, the Administrator Il performance evaluations employees. ATION OF PATIENT	G	143			
	interview, the agency maintained liaison an	ew, document review and failed to ensure staff d coordination of care for 7 ts #1, 5, 6, 8, 9, 10, 11).					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
		297107	B. WING		20/40/2020		
NAME OF DE	OVIDER OR SUPPLIER	29/10/			09/18	3/2009	
	NS CHOICE HOME HEAD	LTH CARE INC	60	EET ADDRESS, CITY, STATE, ZIP CODE 11 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014			
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G 143	Continued From page	÷ 5	G 143				
	Findings include:						
	Patient #1						
	pressure ulcer of the lower extremities, der incontinence and gen	9) with diagnoses including great toe, edema of both mentia, hypertension, urinary eralized weakness.					
	evidence skilled nursi therapy (PT) commun	rds lacked documented ng (SN) and physical licated with one another s status, issues and needs.					
	Patient #5						
	Patient #5 was admitt diagnoses including F dementia.	ed on 10/4/08 with Parkinson 's disease and					
	#5 twice a day to prep	vas ordered to see Patient pare and administer n by subcutaneous injection.					
		ho saw Patient #5 for the nted discovery of a new s right heel.					
		ing nurse documented s ashen and mentation					
	evidence the SN who morning and the SN vevening communicate	rds lacked documented saw the patient in the who saw the patient in the ed with each other regarding ew conditions and needs.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297107	B. WIN	G		09/1	8/2009
	NS CHOICE HOME HEA	ALTH CARE INC	•	601	T ADDRESS, CITY, STATE, ZIP CODE WHTNEY RANCH, BLDG #D22 NDERSON, NV 89014		3. 233
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 143	Continued From page	ge 6	G	143			
	including insulin dep macular degeneration hypertension. Patient #6 was seen day for blood sugar preparation and admorders. Patient #6's clinical evidence of communurses seeing the post-16/09. Nursing visit records	by skilled nursing twice a monitoring and insulin ninistration per sliding scale record lacked documented nication between the skilled atient from 6/18/09 through					
	PM, 9/2/09 at 12:00 11:30 AM and 3:30 revealed Patient #6 crackles in the right The clinical record la the other skilled nur- #3's physician was r in the right lower lob Patient #8 Patient #8 was adm diagnoses including mellitus, dementia, of legal blindness. Patient #8's plan of skilled nursing (SN)	PM and 3:30 PM , 9/3/09 at PM and 9/4/09 at 4:00 PM was experiencing fine lower lobe. acked documented evidence se on the case and Patient notified about the fine crackles se over four days.					

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	297107	B. WIN	1G		09/18	8/2009
	LTH CARE INC	'		601 WHTNEY RANCH, BLDG #D22		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION S		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETION DATE
insulin preparation and Two SNs saw Patient clinical record lacked communication betwee the patient's status, is Patient #9 Patient #9 Patient #9 was admitt diagnoses including in hypertension, peptic of thrombosis. Patient #9 was seen to certified nursing assist therapy (PT). Documentation in the the evaluation done to had "rash on butt." To SN was notified by Proportional record lacked indicating PT was disciplinated by the discharge and the Patient #10 Patient #10 Patient #10 Patient #10 was admitted diagnoses including proposed	the administration. If #8 on a regular basis. The adocumentation of the two SNs regarding saues and needs. Ited on 7/11/09 with the the administration and deep vein the two SNs regarding saues and needs. Ited on 7/11/09 with the amatoid arthritis, alcer and deep vein the two skilled nursing (SN), stant (CNA) and physical the area of skin condition on the area o	G	143			
care. The patient wa	s seen by skilled nursing					
	COVIDER OR SUPPLIER NS CHOICE HOME HEAD SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I Continued From page insulin preparation and Two SNs saw Patient clinical record lacked communication between the patient's status, is Patient #9 Patient #9 was admitted diagnoses including in hypertension, peptic in thrombosis. Patient #9 was seen to certified nursing assist therapy (PT). Documentation in the the evaluation done be had "rash on butt." TSN was notified by Popular to the discharge and the patient #10 Patient #10 was admitted in the discharge and the patient #10 Patient #10 was admitted in the discharge and the patient #10 was seen assistant (CNA) two to the patient #10 was admitted the patient #10 was seen assistant (CNA) two to the patient #10 was admitted the	CORRECTION Z97107 COVIDER OR SUPPLIER NS CHOICE HOME HEALTH CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 insulin preparation and administration. Two SNs saw Patient #8 on a regular basis. The clinical record lacked documentation of communication between the two SNs regarding the patient's status, issues and needs. Patient #9 Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis. Patient #9 was seen by skilled nursing (SN), certified nursing assistant (CNA) and physical therapy (PT). Documentation in the area of skin condition on the evaluation done by PT revealed Patient #9 had "rash on butt." There was no documentation SN was notified by PT of the rash. Documentation in Patient #9's clinical record revealed PT was discontinued on 8/7/09. The clinical record lacked documented evidence indicating PT communicated the update regarding the discharge and the patient's status to the SN. Patient #10 Patient #10 Patient #10 was admitted on 6/5/09 with diagnoses including pressure ulcer of the buttock, failure to thrive, dementia, hypertension and	IDENTIFICATION NUMBER: 297107 A. BUI 297107 ROUIDER OR SUPPLIER NS CHOICE HOME HEALTH CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 insulin preparation and administration. Two SNs saw Patient #8 on a regular basis. The clinical record lacked documentation of communication between the two SNs regarding the patient's status, issues and needs. Patient #9 Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis. Patient #9 was seen by skilled nursing (SN), certified nursing assistant (CNA) and physical therapy (PT). Documentation in the area of skin condition on the evaluation done by PT revealed Patient #9 had "rash on butt." There was no documentation SN was notified by PT of the rash. Documentation in Patient #9's clinical record revealed PT was discontinued on 8/7/09. The clinical record lacked documented evidence indicating PT communicated the update regarding the discharge and the patient's status to the SN. Patient #10 Patient #10 was admitted on 6/5/09 with diagnoses including pressure ulcer of the buttock, failure to thrive, dementia, hypertension and urinary incontinence. Patient #10 was seen by a certified nursing assistant (CNA) two times a week for personal	A BUILDIN B. WING	CONTRECTION DENTIFICATION NUMBER: 297107 S. WING	COMPLET 297107 STREET ADDRESS, CITY, STATE, ZIP CODE 601 WITNEY RANCH, BLDG 8022 HENDERSON, NV 89014 SUMMARY STATEMENT OF DEPCISIONES (EACH DEPCISIONE IN SPECIAL PROPERTIES OF STREET ADDRESS), NV 89014 SUMMARY STATEMENT OF DEPCISIONES (EACH DEPCISIONE) (EACH DEPCISION) (EACH DEPCISIONE) (EACH D

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297107	B. WIN	G		09/18/2009	
	OVIDER OR SUPPLIER	LTH CARE INC	•	60	EET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 144	pressure readings of and 198/88 for Patient documentation on the indicating the CNA not abnormally high blood. Patient #11 Patient #11 was admit diagnoses chronic ob Patient #11 was seen certified nursing assist record lacked docume disciplines communic regarding the patient 484.14(g) COORDINASERVICES The clinical record or conferences establish reporting, and coordin occur. This STANDARD is a Surveyor: 25418 Based on record revie interview, the agency conferences occurred	e CNA documented blood 156/104, 179/99, 184/99 at #10. There was no e CNA or the SN notes officed SN regarding the dipressure readings. It the control of t		143			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	' '	CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
			A. BUILDING				
		297107	B. WING		09	/18/2009	
	ROVIDER OR SUPPLIER	LTH CARE INC	601	T ADDRESS, CITY, STATE, ZIP CODE WHTNEY RANCH, BLDG #D22 IDERSON, NV 89014			
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G 144	Patient #1 Patient #1 was admit including pressure ultof both lower extremi urinary incontinence On 1/15/09, Patient # acute care facility and agency. The clinical record for case conference form filled out and signed reviewed by the Direct (DPS). Under the coread, "Skilled nurse to per MD's order, teach s/s (signs and symptogoals the note read, "note read, "discharge needed." Patient #3 Patient #3 Patient #3 Patient #3 was admit diagnoses including paftercare for a fracture dependent diabetes in Patient #3 was seen home health assistant. Patient #3's clinical revidence of case conthe different discipline	ted on 8/1/08 with diagnoses cer of the great toe, edema ties, dementia, hypertension, and generalized weakness. If was transferred to an didischarged from the repatient #1 contained a nidated 1/26/09 which was by the office manager and ctor of Professional Services mments section the note of continue with wound care ning patient and caregivers oms) of infection. Under l'Ongoing." Under Plan the when skilled care no longer ted on 6/15/09 with pressure ulcer of the heel, ed tibia/fibula and insulin	G 144				

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G 144	Continued From page Patient #5 Patient #5 was admit diagnoses including Indementia. The clinical record for documented evidence completed at the mid periods. Patient #6 Patient #6 was admit including insulin dependence of case conform the certification periods. Patient #6's clinical revidence of case conform the certification periods. Patient #9 Patient #9 Patient #9 Patient #9 was admit diagnoses including insuling including includi	ted on 10/4/08 with Parkinson's disease and r Patient #5 lacked e of case conferences way point of certification ted on 3/1/07 with diagnoses endent diabetes mellitus, n, legally blind and ecord lacked documented afterence at the midway point riod of 6/18/09 through ted on 7/11/09 with theumatoid arthritis,		144	DEFICIENCY)	PKIATE	DAIL
		he period of 7/11/09 through					
	Patient #11						
	Patient #11 was adm diagnoses including of pulmonary disease.						

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	OVIDER OR SUPPLIER	LTH CARE INC	•		REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	,	
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G 144	Continued From page	e 11	G	144	4		
		record lacked evidence of m 1/19/09 through 9/18/09.					
	Patient #13						
	Patient #13 was adm diagnoses including i mellitus and urinary in	nsulin dependent diabetes					
	i i	t #13's clinical record lacked e of a case conference.					
	Patient #15						
	Patient #15 was adm exacerbation of chror disease.	itted on 7/3/09 with nic obstructive pulmonary					
	i i	t #15's clinical record lacked e of a case conference.					
	Case Conferences, "	ncy's undated policy, C-8882. Case Conferences will cert for each patient"					
	talk to each other about it just doesn't get writ manager was suppostype up what they sai stack of them and I'd	ted to call the nurse and then d - he would bring me a sign off - we took that (task) do case conference after					
G 145	484.14(g) COORDIN SERVICES	ATION OF PATIENT	G	14	5		
		port for each patient is sent cian at least every 60 days.					

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G 145	Continued From page	e 12	G	145			
	This STANDARD is Surveyor: 25418	not met as evidenced by:					
	ensure a complete 60	ew, the agency failed to) day summary was patients (Patients #1, 5, 6, 8,					
	Findings include:						
	Patient #1						
	including pressure ulder of both lower extremitation urinary incontinence of the following states of the following pressure ulder of the following pressure ulder of the following pressure under the following pressure un	ted on 8/1/08 with diagnoses cer of the great toe, edema ties, dementia, hypertension, and generalized weakness. prepared for Patient #1 on eft foot wd (wound) care trated procedure well. re c (with) (name), NP RN (registered nurse) and ving facility caregiver. re, drsg (dressing) change, ications as prescribed, pt and compliance. F/U					
	The 60 day summary 1) the progress or lack wound made over the beginning size and do and surrounding skin color of any drainage the specific wound ca of the 60 days; 5) how	lacked information detailing the of progress Patient #1's to previous 60 days; 2) the escription of the wound bed (3) the amount, type and (or that there was none); 4) are ordered at the beginning of the wound responded to did not respond positively),					

297107 NAME OF PROVIDER OR SUPPLIER	B. WIN	G STREET ADDRESS, CITY, STATE, ZIP 601 WHTNEY RANCH, BLDG #D2	•	18/2009
NAME OF PROVIDER OR SUPPLIER	ID		•	
PHYSICIANS CHOICE HOME HEALTH CARE INC	ID	HENDERSON, NV 89014	22	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU TAG REGULATORY OR LSC IDENTIFYING INFORMAT	JLL PREF		ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE
What changes were made and how the wour responded to the new treatment; 6) any new problems that arose and what actions were taken; 7) any changes made to the patient's medications during the 60 day certification p 8) the fact that physical therapy (PT) saw the patient; and 9) how the patient responded to Patient #5 Patient #5 Patient #5 was admitted on 10/4/08 with diagnoses including Parkinson's disease at dementia. Patient #5's clinical record lacked a 60 day summary including the patient's status at the beginning of the certification period, what treatments and care were provided during the past 60 days, how the patient was tolerating treatments and care, any new issues that developed (a new wound on the right foot) a action(s) taken, and plans for the next certification, including discharge plans. Patient #6 Patient #6 was admitted on 3/1/07 with diag including insulin dependent diabetes mellitus macular degeneration, legally blind and hypertension. Patient #6's clinical record lacked a 60 day summary including the patient's status at the beginning of the certification period, ranges blood glucose results for the previous 60 day treatments and care provided during the patient and care, any new issues that developed, the that the patient went to the emergency room	ned of period; ee of the and cation noses s, ee of ys, st 60 outs he fact	145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	IG		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC		6	REET ADDRESS, CITY, STATE, ZIP CODE 101 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 145	7/31/09 - 8/2/09 (and frequently requested themselves and plans) Patient #8 Patient #8 was admit diagnoses including i mellitus, dementia, collegal blindness. Patient #8's clinical resummary including the beginning of the certiblood glucose results treatments and care days, how the patient and care, any new is plans for discharge. Patient #9 Patient #9 was admit diagnoses including rhypertension, peptic thrombosis. Patient #9's clinical resummary. Patient #11 Patient #11 was admidiagnoses chronic ob As of 9/18/09, the patient plans in patient patient was admit diagnoses chronic ob As of 9/18/09, the patient patient was admit diagnoses chronic ob As of 9/18/09, the patient patient was admit diagnoses chronic ob As of 9/18/09, the patient patient was admit diagnoses chronic ob As of 9/18/09, the patient was admit diagnoses chronic ob As of 9/18/09, the patient was admit diagnoses chronic ob As of 9/18/09, the patient was admit diagnoses chronic ob As of 9/18/09, the patient was admit diagnoses chronic obtations and the patient was admit diagnoses chronic obtat	and was hospitalized from why) the fact that the family to provide care by so for discharge. Ited on 4/29/08 with insulin dependent diabetes ongestive heart failure and ecord lacked a 60 day in patient's status at the fication period, ranges of information for the previous 60 days, provided during the past 60 intolerated the treatments is sues that developed and ited on 7/11/09 with inheumatoid arthritis, fulcer and deep vein ecord lacked a 60 day	G	145			
G 158	clinical record.	E OF PATIENTS, POC,	G	158			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED				
		297107	B. WIN	IG _		09/18	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	'	6	REET ADDRESS, CITY, STATE, ZIP CODE 501 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 158	and periodically revie osteopathy, or podiate osteopathy, or podiate This STANDARD is a Surveyor: 25418 Based on record revie ensure care provided care as established be patients (Patients #1, 15). Findings include: Patient #1 Patient #1 was admittincluding pressure ulder of both lower extremiting urinary incontinence at the patient #1's plan of care certification period of included wound care with NS (normal saling (lodosorb) cover with and tape." Patient #1's clinical renursing visit record (Nocumented, "Left footbased and the period of the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the period of the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the period of the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the period of the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented, "Left footbased and the patient #1's clinical renursing visit record (Nocumented) #1's clinical renursing visit record (Nocumented) #1's clinical renursing visit	ric medicine. Interpretation of the properties of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness. Interpretation of the great toe, edema ties, dementia, hypertension, and generalized weakness.	G	158			
	documented, "clear	isea with wa (wound)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		297107	B. WING		09/1	8/2009
	ROVIDER OR SUPPLIER	LTH CARE INC	s	TREET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 158	physician's order in the wound care. A NVR dated 9/16/08 regarding wound care. On 9/17/08, the nurse Physician's Orders/Ples. Weight monitoring NVRs in Patient #1's documented evidence 9/22/08 or 9/24/08. The patient weekly was not certification period of even though the patient edema in both lower diuretic treatment. The 12/2/08 NVR comphysician was aware weight, however, the on the NVR dated 12 Patient #1's plan of certification period of through 11/28/08 incles (SN) frequencies of the NVR dated 12 Patient #1's plan of certification period of the NVR dated 12 Patient #1's plan of certification was aware weight, however, the on the NVR dated 12 Patient #1's plan of certification weeks and then one the SN: saw Patient #1 oweek, did not see the saw the patient one tit two times a week for for one week, did not	lacked any documentation to the left foot. wrote on a Verification of an of Care Update, once weekly" clinical record lacked weights were done on the order to weigh the ot carried over into the 9/30/08 through 11/28/08, ent was still experiencing extremities and was on that and documentation the of Patient #1's current weight was not documented /2/08. are for the period 9/30/08 uded orders for skilled nurse wo times a week for six time a week for three weeks. Intation in the clinical record, ne time a week for three weeks, one week, one time a week see the patient during the y the patient two times a	G 15	58		

I ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	\ /	(X3) DATE SURVEY COMPLETED	
		297107	B. WING		00	/18/2009	
	ROVIDER OR SUPPLIER	1	6	REET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 IENDERSON, NV 89014	03	716/2009	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 158	clinical record indicaregarding the chang to be provided. The Plan of Care Update frequency. Patient #3 Patient #3 Patient #3 was adm diagnoses including aftercare for a fractude dependent diabetes Patient #3's clinical order for the right he cleansed with "wourdated 7/17/09. A SN documented onursing notes the rigwith normal saline. The 7/17/09 physicial frequency for SN to wound care two times. According to document #3 of 7/26/09. There was clinical record to dea for that week. According to the pla profile (MP), Patient mg one by mouth every each nostril every diagrams.	nentation in Patient #1's ting SN notified the physician es in the number of SN visits clinical record did not have a to change the SN visit tted on 6/15/09 with pressure ulcer of the heel, red tibia/fibula and insulin mellitus. record included a physician's rel pressure ulcer to be ad wash." The order was n 10 different dated skilled an's order included a visit Patient #3 and provide	G 158				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297107	B. WING		09/	18/2009
	ROVIDER OR SUPPLIER	LTH CARE INC	601	ET ADDRESS, CITY, STATE, ZIP CODE I WHTNEY RANCH, BLDG #D22 NDERSON, NV 89014	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 158	well as Lortab 7.5/50 every 4 hours; and C mouth every other da on the alternate days On 9/11/09 in the after and the alternate days On 9/11/09 in the after and the alternate days - she no longer need physician was aware 3/13/09; - the physician change milligrams on 9/10/09 - she stopped using the physician discoon 6/15/09; - she was no longer 500 milligrams one to was all she was taking the was taking the she was taking it since 8/27/09 - she had been taking mouth every day since the was taking Coumouth Monday through milligrams by mouth of the MP lacked docur regarding the change medications.	O milligram one by mouth oumadin 3 milligrams by and 5 milligrams by mouth out and 5 milligrams by mouth out and 5 milligrams by mouth out and 5 milligrams and her she stopped taking it on a ged the Lasix to 40 out of the Nasonex on 7/4/09; and the Lidoderm patch out atking Lortab and Tylenol ablet by mouth at bedtime g for pain; aribed Lisinopril 5 milligrams day and the patient had been out on the state of the patient of	G 158			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILD				
		297107			09	/18/2009	
	OVIDER OR SUPPLIER NS CHOICE HOME HEA	ALTH CARE INC		STREET ADDRESS, CITY, STATE, ZIP CO 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 158	visit; 2) change bed observe fall precautions with mouth care. documentation indication of completed during was no documentation communicated with to change the care process. Twenty-six of 26 CN indicating the CNA conditions twice a week. None of the 26 CNA documentation indicating the CNA conditions while process of 26 CNA notes indicating the CNA consils. The Care Plan nurse did not include care. There was no CNA contacted the SP Patient #4 Patient #4 Patient #4 was admidiagnoses including non-insulin dependent hypertension. Patient #4's care plan nursing (SN) to see for one week, one times in the contact of the second contact in the care plan nursing (SN) to see for one week, one times in the care plan nursing (SN) the care plan	linens once a week; and 3) ons. A notes lacked documented erformed or assisted Patient There was no ating why the mouth care was greach of the 26 visits. There on indicating the CNA the nurse regarding the need olan. A notes had documentation changed Patient #3's bed notes included ating the CNA observed fall oviding care to Patient #3. included documentation eleaned/filed Patient #3's in prepared by the registered erinstructions to provide nail documentation indicating the SN to revise the care plan.	G 1	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297107	B. WING		09/1	8/2009
	NS CHOICE HOME HEA	LTH CARE INC	60	EET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 IENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 158	Continued From page	≥ 20	G 158			
	#4's clinical record, S the first week.	nursing visit notes in Patient N saw the patient one time				
		ted on 3/1/07 with diagnoses endent diabetes mellitus, n, legally blind and				
	period of 6/18/09 throto be seen by skilled The clinical record watime frame. The clinidocumentation indicamissed. There was n	are for the certification ough 8/16/09 included orders nursing (SN) twice a day. as missing 12 visits for this cal record lacked ating why each visit was no physician's order to ts during this certification				
	period of 8/17/09 thro orders to be seen by day. The clinical reco this time frame. The documentation indica	nting why each visit was record lacked a physician's				
	Patient #7					
	Patient #7 was admit diagnoses including h muscle weakness an	nypertension, generalized				
	Patient #7's plan of c	are included orders for				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	G		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	1	60	EET ADDRESS, CITY, STATE, ZIP CODE D1 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 158	week for nine weeks; to evaluate; and physical patient one time a week for According to docume record: - SN saw the patient record lacked a physical signs one Patient #8's clinical recording to document the patient week; two times a week for one valued a physician's ovisits. Patient #8 Patient #8 was admit diagnoses including in mellitus, dementia, collegal blindness. Patient #8's clinical recording the patient week; two times a week for one valued a physician's ovisits.	o see the patient once a occupational therapy (OT) sical therapy (PT) to see the sek for one week and then, three weeks. Ints in Patient #7's clinical one time. The clinical ician's order to discontinue opatient. The clinical record evidence explaining why OT ent. Interpretation one time a week for one seek for one week and one week. The clinical record order to decrease the PT Interpretation of the property	G	158			
	Patient #10						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	IG		09/18	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•	6	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 158	Continued From page	e 22	G	158			
	failure to thrive, deme urinary incontinence. Patient #10's plan of certified nursing assis week for nine weeks 8/4/09 through 10/2/0 The CNA saw Patient first week of the certifithrough 10/2/09. Patient #11 Patient #11 was adm diagnosis of chronic of disease. Patient #11's plan of the certifithrough 10/2/09.	care included orders for stant (CNA) two times a for the certification period of 9. t #10 one time during the fication period of 8/4/09					
		one time the first week; then at the second and third week.					
	Patient #13						
	Patient #13 was adm diagnoses including in mellitus and urinary in	nsulin dependent diabetes					
	physical therapy (PT)	care included orders for to see the patient three week and two times a week					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	297107	B. WIN	G		09/1	8/2009
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEA	LTH CARE INC	•	601	ET ADDRESS, CITY, STATE, ZIP CODE WHTNEY RANCH, BLDG #D22 NDERSON, NV 89014		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
PT saw Patient #13 to weeks and one time of physician's order in the change in PT nurse for Patient #14 Patient #14 was admediagnoses including order the following of skilled nursing (SN) to week and then, one to the patient for two were patient on 9/9/09 to depend order changing the Section of chrorodisease. Patient #15 was admediagnoses admediagnoses and the patient for two were patient on 9/9/09 to depend order changing the Section of chrorodisease. Patient #15 was admediagnoses and exacerbation of chrorodisease. Patient #15's plan of skilled nursing (SN) of week, two times a week for section of the patient and week for section of the patient #15 one plant the patient #15 one pl	intation in the clinical record, wo times a week for four for one week. There was no ne clinical record indicating a requency. itted on 8/11/09 with non-insulin dependent a fractured left shoulder. care included orders for wo times a week for one ime a week for eight weeks. Intation in the clinical record, hree times a week for one ek for one week; did not see eeks and then, saw the ischarge from PT record lacked a physician's N visit frequencies. itted on 7/3/09 with nic obstructive pulmonary care included orders for one time a week for one ek for two weeks and then,	G	158			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SUF COMPLET	
		297107	B. WIN	G		09/1	8/2009
	ROVIDER OR SUPPLIER	LTH CARE INC	•	60	EET ADDRESS, CITY, STATE, ZIP CODE 1 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 158	then, did not see the of the certification pe 8/31/09). There was clinical record to char Patient #15's plan of certified nursing assis week for nine weeks. Documentation in the CNA did not see Pati weeks and saw the pweek. There was no clinical record to char Patient #15's plan of physical therapy (PT) week and then two times the sum of	a week for five weeks and patient during the last week riod (7/3/09 through no physician's order in the nge the SN frequency. care included orders for a stant (CNA) two times a c clinical record revealed the ent #15 for the first two atient only one time the third physician's order in the nge the CNA visit frequency. care included orders for one time a week for one mes a week for two weeks. c order extended PT visits	G	158			
G 163	saw Patient #15 one two times a week for time a week for one wonote for the fourth we 484.18(b) PERIODIC CARE The total plan of care physician and HHA proposed severity of the patient least once every 60 of there is a beneficiary significant change in change in the case-matischarge and return	is reviewed by the attending ersonnel as often as the t's condition requires, but at lays or more frequently when elected transfer; a condition resulting in a	G	163			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297107	B. WIN	G		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	'	60	EET ADDRESS, CITY, STATE, ZIP CODE D1 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 163	change in the case-in discharge and return 60 day episode. This STANDARD is Surveyor: 25418 Based on record revi interview, the agency the physician reviewe every 60 days for 5 of 11, 13, 15). Findings include: Patient #3 Patient #3 was admit diagnoses including aftercare for a fractur dependent diabetes in Patient #3's certified plan was prepared air registered nurse (RN documentation on the reviewed it during the 6/15/09 through 8/13 Patient #9 Patient #9 was admit diagnoses including in hypertension, peptic thrombosis. No OASIS (Outcome	elected transfer; a condition resulting in a nix assignment; or a to the same HHA during the not met as evidenced by: ew, document review and a failed to ensure staff and ed the plan of care at least of 15 patients (Patients #3, 9, and the dibia/fibula and insulin mellitus. nursing assistant (CNA) care and dated 6/15/09 by the dibia/fibula and insulin mellitus. nursing assistant (CNA) care and dated 6/15/09 by the dibia/fibula and insulin mellitus. tend dated 6/15/09 with the care plan indicating the RN at 60 day time frame of from the condition of the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of from the care plan indicating the RN at 60 day time frame of frame frame of frame fra	G	163			
		and Assessment as were completed during the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297107	B. WIN	IG	·····	09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC		60	REET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 IENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 163	period. Therefore, no was generated. As of 9/18/09, Patient contain a plan of care from 9/9/09 through of Patient #11 Patient #11 was admidiagnoses chronic obtained in the Information Set) formulast five days of each Therefore, no plans of generated for any of As of 9/18/09, Patient contain a plan of care period of 9/16/09 through the Information Set) formulation set including it mellitus and urinary in No OASIS (Outcome Information Set) formulast five days of the in Patient #13. Therefore orders) was generated period. Patient #15	ant #9 's initial certification or plan of care (with orders) It #9's clinical record did not a for the certification period 1/8/09. It #0's clinical record did not a for the certification period 1/8/09. It #0's clinical record did not a four certification periods. It #11's clinical record did not a for the current certification periods. It #11's clinical record did not a for the current certification period 1/1/14/09. It #11's clinical record did not a for the current certification period for the current diabetes and Assessment and Assessment s were completed during the initial certification period for the current certification period for the current certification did for the current certification	G	163			
	Patient #15 was adm	itted on 7/3/09 with					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF	
		297107	B. WIN	IG_		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•		REET ADDRESS, CITY, STATE, ZIP CODE 501 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		5. 2 000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 163	No OASIS (Outcome Information Set) form last five days of the ir Patient #15. Therefo orders) was generate period of 9/1/09 through The physician did not Patients #9, 11, 13 and drives the generation of care and no OASIS According to the agen Plan of Care, " 8. The reviewed by the at as the severity of the but at least one time. On 9/17/09 in the after professional services been told by the Med maintenance organizationly needed to compinitial admission and the HMO patients.	and Assessment s were completed during the nitial certification period for re, no plan of care (with rd for the current certification righ 10/30/09. Treview the plans of care for rd 15 since the OASIS and preparation of the plan s forms were completed. Incy's undated policy, C-480 The total Plan of Care shall ttending physician as often client's condition requires, every 60 days"		163			
	Drugs and treatments agency staff only as o	s are administered by ordered by the physician.					
	This STANDARD is Surveyor: 25418	not met as evidenced by:					
	Based on record revi	ew and document review,					

NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC STREET ADDRESS, CITY, STATE, JOP CODE 601 WHTNEY BANCH, BLDG #022 HENDERSON, NV 39014 MANUAL PREFIX TAG. PREF		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
PHYSICIANS CHOICE HOME HEALTH CARE INC CALL DESCRIPTION SUMMANY STATEMENT OF DEFICIENCES SOT WITNEY RANCH, BLDG #022 HENDERSON, NV 38014 FEMERET AND SUMMANY STATEMENT OF DEFICIENCES PREFIX TAG FEMERET AND SUMMANY STATEMENT OF DEFICIENCES PREFIX TAG FEMERET AND SUMMANY STATEMENT OF DEFICIENCES PREFIX TAG FEMERET AND RESERVED TO THE APPROPRIATE CANONIC AND STATEMENT OF DEFICIENCES PROPERTY TAG CONTINUED FROM PROPERTY TAG CO			297107	B. WIN	IG		09/1	8/2009
PREFIX TAG RESULATORY OR LISC IDENTIFYING INFORMATION) RESULATORY OR LISC IDENTIFYING INFORMATION) RESULATORY OR LISC IDENTIFYING INFORMATION) G 165 Continued From page 28 the agency failed to ensure medication and treatments were administered only as ordered by the physician for 9 of 15 patients (Patients #1, 3, 9, 10, 11, 12, 13, 14, 15). Findings include: Patient #1 Patient #1 was admitted on 8/1/08 with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness. Patient #1's plan of care for the certification period of 8/1/08 through 9/29/08 included orders for wound care as follows: cleanse with NS (normal saline), pat dry, apply indoserb (lodosorb) cover with 4X4 then secure with 4X4 and kerlix and tape 3X/week. Incisional care: keep incision clean, dry and intact, keep dressing dry and intact" On the nursing visit record (NVR) dated 9/12/08 regarding the left foot wound, the SN documented, " cleansed with wound cleanser, pat dry, left open to air" The plan of care for the period of 11/29/08 through 01/27/09 orders for the left foot wound read, " cleanse with wound cleanser, pat dry, apply thin tegasorb and secure with tape." NVRs dated 12/4/08, 12/12/08, 12/119/08, 12/22/08 and 14/4/09 revealed the nurse soaked			LTH CARE INC	•	60	01 WHTNEY RANCH, BLDG #D22	•	
the agency failed to ensure medication and treatments were administered only as ordered by the physician for 9 of 15 patients (Patients #1, 3, 9, 10, 11, 12, 13, 14, 15). Findings include: Patient #1 Patient #1 Patient #1 was admitted on 8/1/08 with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness. Patient #1's plan of care for the certification period of 8/1/08 through 9/29/08 included orders for wound care as follows: cleanse with NS (normal saline), pat dry, apply iodoset (lodosorb) cover with 4/X4 then secure with 4/X4 and kerlix and tape 3X/week. Incisional care: keep incision clean, dry and intact On the nursing visit record (NVR) dated 9/12/08 regarding the left foot wound, the SN documented, " cleansed with wound cleanser, pat dry, left open to air" The plan of care for the period of 11/29/08 through 01/27/09 orders for the left foot wound read, " cleanse with wound cleanser, pat dry, apply thin tegasorb and secure with tape." NVRs dated 12/4/08, 12/12/08, 12/19/08, 12/22/08 and 1/4/09 revealed the nurse soaked	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
clinical record lacked a physicians order for Betadine soaks to the left foot.	G 165	the agency failed to extreatments were admit the physician for 9 of 9, 10, 11, 12, 13, 14, Findings include: Patient #1 Patient #1 was admit including pressure ul of both lower extremi urinary incontinence Patient #1's plan of coperiod of 8/1/08 through of 8/1/08 through of wound care as fol (normal saline), pat of cover with 4X4 then and tape 3X/week incision clean, dry and and intact" On the nursing visit regarding the left foo documented, " clean pat dry, left open to a through 01/27/09 ord read, " Cleanse with apply thin tegasorb a NVRs dated 12/4/08, 12/22/08 and 1/4/09 Patient #1's left foot is clinical record lacked	ensure medication and hinistered only as ordered by 15 patients (Patients #1, 3, 15). Interest on 8/1/08 with diagnoses cer of the great toe, edema tities, dementia, hypertension, and generalized weakness. Interest of the certification ugh 9/29/08 included orders llows: cleanse with NS lry, apply iodoserb (Iodosorb) secure with 4X4 and kerlix. Incisional care: keep indicated interest keep indicated the cord (NVR) dated 9/12/08 it wound, the SN lansed with wound cleanser, hir" The period of 11/29/08 lers for the left foot wound in wound cleanser, pat dry, and secure with tape." 12/12/08, 12/19/08, revealed the nurse soaked in Betadine. The patient's it a physicians order for	G	165			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297107	B. WIN	G		09/1	8/2009
	ROVIDER OR SUPPLIER	LTH CARE INC	•	60	EET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 165	entire clinical record of Nursing acknowledge Betadine in the chart. According to the ager Physicians Orders, "A and services provided ordered by a physicial orders shall be maint. Patient #3 Patient #3 was admit diagnoses including pattercare for a fractur dependent diabetes or Patient #3's clinical record (NVR) dated and for the cord (NVR) dated and for the	M after looking through the for Patient #1, the Director of ed, "I don't see an order for " Incy's (undated) policy, C-365 All medications, treatments of to patients must be an 9. All signed physician ained in the clinical record." Ited on 6/15/09 with pressure ulcer of the heel, ed tibia/fibula and insulin mellitus. Record included a nursing visit ed, "The left great toe was mal saline), covered with electron ained and insulin mellitus. Record included a NVR dated SN documented, "The el pressure ulcer and left ed with normal saline. The easured. Triple antibiotic to wound beds" Record included a NVR dated SN documented, "The energy and the electron of the left dated SN documented, "The aned with NS. Antibiotic to right heel The left did with a Band-Aid. The	G	165			

PRINTED: 10/21/2009 FORM APPROVED OMB NO. 0938-0391

	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF	
	297107	B. WIN	G		09/1	8/2009
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CA	RE INC	•	60	EET ADDRESS, CITY, STATE, ZIP CODE 11 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
Patient #3's clinical record in 9/8/09, on which the SN doc wound beds were cleaned w antibiotic cream was applied beds" Patient #3's clinical record in 9/11/09, on which the SN do wound beds were cleaned w Triple antibiotic ointment was bedsDry gauze and Bandgreat toe." Patient #3's clinical record la order for wound care to the I Patient #9 Patient #9 was admitted on diagnoses including rheumal hypertension, peptic ulcer ar thrombosis. Patient #9's clinical record in record (NVR) with document urine specimen was obtained urinalysis and culture and se record lacked a physician's of Patient #9's clinical record in 9/2/09 with documentation in administered Arixtra 5 milligr (subcutaneously)" The clir physician's order for Arixtra. Patient #9's clinical record in dated 9/2/09 through 9/13/09 the patient 12 days in a row. lacked a physician's order for diagonal solution.	umented, "The ith NS. Triple to the wound scluded a NVR dated cumented, "The ith Normal Saline. It is applied to wound Aid applied to left scked a physician's eft great toe. 7/11/09 with toid arthritis, and deep vein scluded a nurse visit sation indicating a don 7/30/09 for ensitivity. The clinical order for these tests. Included a NVR dated adicating the SN " arms SQ nical record lacked a scluded 12 NVRs on indicating SN saw The clinical record	G	165			

Facility ID: NVS3767HHA

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297107	B. WING		09/1	8/2009
	OVIDER OR SUPPLIER NS CHOICE HOME HEA	LTH CARE INC	6	REET ADDRESS, CITY, STATE, ZIP CODE 101 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 165	failure to thrive, demendent urinary incontinence. Patient #10's plan of skilled nursing and coordinated Patient #10's plan of skilled nursing and coordinated Patient #10's evaluated Patient #10's record lacked a signer to evaluate the patient between the patient with the patient #11 was admidiagnoses chronic obout The plan of care including (SN) "every wassistant two times a consistent wo ti	itted on 6/5/09 with pressure ulcer of the buttock, entia, hypertension and care included orders for entified nursing assistant. al social worker (MSW) b. As of 9/18/09, the clinical ed physician's order for MSW entity. itted on 1/19/09 with estructive pulmonary disease, and certified nursing week for two weeks. 1 was admitted to the e initial home health orders resumption of care visit. No end CNA frequencies) were #11.	G 165			
	gonoratou.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297107	B. WIN	IG		09/1	8/2009
	ROVIDER OR SUPPLIER	LTH CARE INC	•	6	REET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 165	Patient #11 was seer physician's orders. T twice a week through without physician's orders. T twice a week through without physician's orders only needed to compinitial admission and Patient #12 Patient #12 was admidiagnosis of exacerb pulmonary disease. Patient #12's plan of skilled nursing (SN) tweek for nine weeks. SN saw the patient twon service. The clinic physician's order for additional visit. Patient #13 Patient #13 Patient #13 was admidiagnoses insulin depand urinary incontine Patient #13's plan of nursing (SN) to change at the control of t	the patient was seen by CNA out four certification periods orders. ernoon, the director of (DPS) indicated they had icare HMO (health ation) referral source they lete the OASIS upon the the final discharge visits. itted on 8/23/98 with a ation of chronic obstructive care included orders for or see the patient one time a vo times during the first week cal record lacked a SN to see Patient #12 for an itted on 7/22/09 with bendent diabetes mellitus ince. care lacked orders for skilled	G	165			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION 3	(X3) DATE SUF COMPLET	
		297107	B. WIN	IG		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	·	6	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 165	diabetes mellitus and Patient #14's plan of skilled nursing (SN) tweek and then, one to According to docume SN saw Patient #14's physician's order to in Patient #15 Patient #15 Patient #15 was adm diagnosis of exacerb pulmonary disease. An 8/5/09 nursing visus nursing (SN) provide Patient #15's upper rows and the same pulmonary disease. As of 9/18/09, there would have the same pulmonary disease. As of 9/18/09, there would have the same polysic patient #15's clinical worker (MSW) note of MSW saw the patient There was no physic patient #15's clinical	nitted on 8/11/09 with non-insulin dependent if a fractured left shoulder. care included orders for wo times a week for one time a week for eight weeks. Intation in the clinical record, three times a week the first clinical record lacked a ncrease SN visit frequencies. Interest in the clinical record is three times a week the first clinical record lacked a ncrease SN visit frequencies. Interest in the clinical record, three times a week the first clinical record lacked a ncrease SN visit frequencies. Interest in the clinical record, three times a week the first clinical record lacked a ncrease SN visit frequencies. Interest in Table 1 is the clinical record revealed skilled do care for a skin tear to ight arm. In was no physician's order for a document of the care in Patient #15's chart. In record had a medical social dated 8/12/09, revealing the ton 8/11/09. It is not a medical social dated 8/12/09, revealing the ton 8/11/09. It is not a medical social dated 8/12/09, revealing the ton 8/11/09.	G	165			
		ncy's undated policy, C-480 Professional staff shall					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		297107	B. WIN	IG		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•	6	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 165	Continued From page	e 34	G	165			
G 168	promptly alert the phy suggest a need to alto 484.30 SKILLED NUI		G	168			
G 169	Surveyor: 25418 The agency: failed to services by or under registered nurse (G16 nursing services in accare (G170); failed to initiated necessary re (G173); failed to ensure prepared clinical and informed the physicial changes in the patient (G176); and failed to participated in in-service supervised and taught (G178). The cumulative effect resulted in the agency provision of federally services. 484.30 SKILLED NUME The HHA furnishes slunder the supervision of the supervision of the supervision that supervision the supervision of the supe	sey); failed to furnish skilled coordance with the plan of ensure the skilled nurse visions to the plan of care are the skilled nurse progress notes and n and other personnel of t's condition and needs ensure the skilled nurse rice programs, and at other nursing personnel of these systemic problems y's inability to ensure the mandated skilled nursing	G	169			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		297107	B. WIN	IG_		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•		REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 169	reviewed. Personnel employees lacked do supervisory visits wernurse (Employees #2) According to the ager Clinical Supervision, therapeutic services supervision of a Regiof Professional Servic Registered Nurse will ongoing supervision of the Agency 1. The Services shall be rescare provided and suproviding therapeutic staff 5. On-site sureceiving services will Case Manager to direct evaluate the implementand the delivery of semethod of supervision amount and type of complaints, and charton Professional Services	ersonnel records were records for 6 of 7 cumented evidence re conducted by a registered 3, 4, 5, 6, 7). Incy's undated policy, C-300 "Skilled nursing and other are provided under the stered Nurse. The Director ces or a designated qualified be available to provide during the operating hours of Director of Professional ponsible for the quality of pervision of all staff services, including contract pervision of patients be performed by the RN ect, demonstrate, and entation of the Plan of Care ervices. The frequency and in will be based on the are provided, patient tiges in patient condition"		169			
G 170		killed nursing services in	9	170			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	IG		09/18	8/2009	
	ROVIDER OR SUPPLIER	LTH CARE INC	,	6	REET ADDRESS, CITY, STATE, ZIP CODE 101 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	VE ACTION SHOULD BE ED TO THE APPROPRIATE		
G 170	Continued From page	e 36	G	170				
	Surveyor: 25418 Based on record reviensure care provided care as established be patients (Patients #1, 15). Findings include: Patient #1 Patient #1 was admit including pressure ule of both lower extremi urinary incontinence and present with NS (normal salin (lodosorb) cover with and tape." Patient #1's clinical renursing visit record (N documented, "Left for cleanser, pat dry, cov. On Patient #1's 9/12 documented, "clear cleanser, pat dry, left physician's order in the wound care.	8/1/08 through 9/29/08 orders which read, "Cleanse e), pat dry apply lodoserb 4X4 then secure with kerlix ecord contained a 9/9/08 NVR)on which the nurse ot cleansed with wd (wound) ered with thin Tegasorb" //08 NVR the nurse nsed with wd (wound) open to air" There was no ne record to change the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297107	B. WING _		09/	18/2009
	OVIDER OR SUPPLIER	LTH CARE INC	ST	TREET ADDRESS, CITY, STATE, ZIP COI 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	/IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)	
G 170	Continued From page	e 37	G 17	0		
	Physician's Orders/P "Weight monitoring NVRs in Patient #1's documented evidence 9/22/08 or 9/24/08. T patient weekly was no certification period of even though the patie	once weekly"				
	physician was aware	ntained documentation the of Patient #1's current weight was not documented /2/08.				
	through 11/28/08 incl (SN) frequencies of the	are for the period 9/30/08 uded orders for skilled nurse wo times a week for six time a week for three weeks.				
	SN saw Patient #1 or did not see the patier patient one time a we times a week for one one week, did not see	ntation in the clinical record, ne time a week for one week, at the second week, saw the eek for three weeks, two week, one time a week for the patient during the or the patient two times during				
	clinical record indicat regarding the change to be provided. The	entation in Patient #1's ing SN notified the physician is in the number of SN visits clinical record did not have a to change the SN visit				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	1G		09/18	8/2009	
	OVIDER OR SUPPLIER	LTH CARE INC	,		REET ADDRESS, CITY, STATE, ZIP CODE 501 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		_D BE	(X5) COMPLETION DATE	
G 170	Continued From page	e 38	G	170				
	aftercare for a fracture dependent diabetes in Patient #3's clinical recorder for the right head cleansed with "wound dated 7/17/09. A SN documented on nursing notes the right with normal saline. The 7/17/09 physicial frequency for SN to vivound care two times. According to docume SN saw Patient #3 or 7/26/09. There was in clinical record to deer for that week. According to the plan profile (MP), Patient #3 mg one by mouth every deach nostril every day dosage noted) patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the recorder of the patch well as Lortab 7.5/500 every 4 hours; and Corder for the patch well as Lortab 7.5/500 every 4 hours; and Corder for the patch well as Lortab 7.5/500 every 4 hours; and Corder for the patch well as Lortab 7.5/500 every 4 hours; and Corder for the patch well as Lortab 7.5/500 every 4 hours; and Corder for the patch well as Lortab 7.5/500 every 4 hours; and Corder for the patch well as Lortab 7.5/500 every 4 hours; and Corder for the patch well as Lortab 7.5/500 every 4 hours; and Corder for the patch well as Lortab 7.5/500 every 4 hou	pressure ulcer of the heel, ed tibia/fibula and insulin mellitus. ecord included a physician's el pressure ulcer to be di wash." The order was a 10 different dated skilled at heel wound was cleansed in's order included a isit Patient #3 and provide a week. Intation in the clinical record, the time during the week of the physician's order in the rease the visits to one time of care and medication #3 was to take Protonix 40 ery day; Lasix 10 milligrams day; use Nasonex one spray y, apply a Lidoderm (no for 12 hours every day, as 0 milligram one by mouth oumadin 3 milligrams by y and 5 milligrams by mouth						
	On 9/11/09 in the after	ernoon, Patient #3 indicated:						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		297107	B. WIN	1G		09/1	8/2009
	NS CHOICE HOME HEA	LTH CARE INC	•	•	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE	
G 170	Continued From page	e 39	G	170			
		ed the Protonix and her she stopped taking it on					
	- the physician chang milligrams on 9/10/09						
	- she stopped using	the Nasonex on 7/4/09;					
	- the physician disco on 6/15/09;	ntinued the Lidoderm patch					
		taking Lortab and Tylenol blet by mouth at bedtime g for pain;					
		ribed Lisinopril 5 milligrams lay and the patient had been 9;					
	- she had been takin mouth every day sind	g a multivitamin one by e 3/13/09; and					
	mouth Monday through	umadin 5 milligrams by gh Saturday and Coumadin 3 on Sundays since 9/8/09.					
		mented evidence of updates s made to Patient #3's					
	assistant (CNA) inclu	n for the certified nursing ded 1) mouth care every nens once a week; and 3) ans.					
		A notes lacked documented rformed or assisted Patient					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297107	B. WING		09/	18/2009
	ROVIDER OR SUPPLIER	LTH CARE INC	60	EET ADDRESS, CITY, STATE, ZIP CODE D1 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 170	not completed during was no documentation communicated with the to change the care plant to change the CNA chandicating the CNA chandicated the Shading the CNA contacted the	There was no ting why the mouth care was each of the 26 visits. There in indicating the CNA ne nurse regarding the need an. A notes had documentation hanged Patient #3's bed notes included ting the CNA observed fall viding care to Patient #3. Included documentation eaned/filed Patient #3's prepared by the registered instructions to provide nail documentation indicating the N to revise the care plan.	G 170			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		297107	B. WING		09/18/2009		
	OVIDER OR SUPPLIER	LTH CARE INC	S	TREET ADDRESS, CITY, STATE, ZIP C 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
G 170	Continued From page	e 41	G 17	70			
		ted on 3/1/07 with diagnoses endent diabetes mellitus, n, legally blind and					
	period of 6/18/09 thro to be seen by skilled The clinical record wa time frame. The clini documentation indica missed. There was r	are for the certification bugh 8/16/09 included orders nursing (SN) twice a day. as missing 12 visits for this cal record lacked uting why each visit was no physician's order to the day of the certification					
	period of 8/17/09 thro orders to be seen by day. The clinical reco this time frame. The documentation indica	are for the certification bugh 10/15/09 included skilled nursing (SN) twice a pord was missing 9 visits for clinical record lacked uting why each visit was record lacked a physician's SN visits during this					
	Patient #7						
	Patient #7 was admit diagnoses including h muscle weakness an	nypertension, generalized					
	skilled nursing (SN) to week for nine weeks; to evaluate; and physic	are included orders for o see the patient once a occupational therapy (OT) sical therapy (PT) to see the eek for one week and then, three weeks.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING				
		297107	B. WING		09	/18/2009	
	ROVIDER OR SUPPLIER	LTH CARE INC	601	T ADDRESS, CITY, STATE, ZIP CODE WHTNEY RANCH, BLDG #D22 NDERSON, NV 89014	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
G 170	According to docume record: - SN saw the patient record lacked a phys SN visits; - OT did not see the lacked documented e had not seen the patient week; two times a we time a week for one viacked a physician's evisits. Patient #8 Patient #8 was admit diagnoses including i mellitus, dementia, collegal blindness. Patient #8's plan of collegal blindness. Patient #8's plan of collegal blindness. Patient #8's clinical reconstruction of vital signs one patient #8's clinical reconstruction. Patient #10 Patient #10 Patient #10 Patient #10 Patient #10 was admit diagnoses including patient #10	one time. The clinical ician's order to discontinue patient. The clinical record evidence explaining why OT ent. one time a week for one eak for one week and one week. The clinical record order to decrease the PT ted on 4/29/08 with nsulin dependent diabetes ongestive heart failure and are included an update with or skilled nursing (SN) to time a week. ecord lacked documentation k of 6/28/09, 7/12/09 and itted on 6/5/09 with oressure ulcer of the buttock, entia, hypertension and	G 170				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	297107	B. WIN	G		09/1	8/2009
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTI	H CARE INC	ļ.	601	ET ADDRESS, CITY, STATE, ZIP CODE 1 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014	, 00/1	3/2000
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		LD BE	(X5) COMPLETION DATE
8/4/09 through 10/2/09. The CNA saw Patient # first week of the certificathrough 10/2/09. Patient #11 Patient #11 was admitted diagnosis of chronic obsidisease. Patient #11's plan of carskilled nursing (SN) to sweek." SN saw Patient #11 one did not see the patient the diagnoses including instruction mellitus and urinary incomplete a week for one we for four weeks. According to documentate PT saw Patient #13 two weeks and one time for	re included orders for nt (CNA) two times a the certification period of 10 one time during the ation period of 8/4/09 and on 1/19/09 with a structive pulmonary re included orders for the the patient "Q (every) at time the first week; then the second and third week. and on 7/22/09 with the time the patient diabetes on timence. The included orders for the see the patient three t	G	170			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	IG		09/18/2009		
	OVIDER OR SUPPLIER	LTH CARE INC		6	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE THE APPROPRIATE		
G 170	Patient #14's plan of skilled nursing (SN) tweek and then, one to According to docume SN saw Patient #14 tweek, one time a weethe patient for two we patient on 9/9/09 to compatient on 9/9/09 to compatient #15's clinical order to change the State Patient #15 was admexacerbation of chroid disease. Patient #15's plan of skilled nursing (SN) of week, two times a week for state Patient #15 one did not see the patient the patient one time a then, did not see the	itted on 8/11/09 with non-insulin dependent a fractured left shoulder. care included orders for wo times a week for one ime a week for eight weeks. Intation in the clinical record, hree times a week for one ek for one week; did not see eks and then, saw the ischarge from the agency. Itted on 7/3/09 with nic obstructive pulmonary care included orders for one time a week for one ek for two weeks and then, six weeks. It clinical record revealed SN time a week for two weeks, at during the third week, saw a week for five weeks and patient during the last week	G	170				
		nod (7/3/09 through no physician's order in the nge the SN visit frequency.						

l, '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297107	B. WIN	IG		09/1	8/2009
	ROVIDER OR SUPPLIER	LTH CARE INC	'	6	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION: TAG CROSS-REFERENCED TO THE A DEFICIENCY)		LD BE	(X5) COMPLETION DATE
G 170	Patient #15's plan of certified nursing assis week for nine weeks. Documentation in the CNA did not see Patiweeks and saw the pweek. There was no clinical record to char Patient #15's plan of physical therapy (PT) week and then two tire A 7/26/09 physician's two times a week for Documentation in the saw Patient #15 one two times a week for time a week for one worte for the fourth we physician's order in the PT visit frequency 484.30(a) DUTIES ONURSE The registered nurse necessary revisions. This STANDARD is Surveyor: 25418 Based on record reviensure the nurse made	care included orders for a stant (CNA) two times a clinical record revealed the ent #15 for the first two atient one time the third physician's order in the nge the CNA visit frequency. care included orders for one time a week for one time a week for one mes a week for two weeks. order extended PT visits two more weeks. clinical record revealed PT time a week for one week, two weeks and then one week. There was no PT visit ek. There was no he clinical record to change of the clinical re		170			

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		297107	B. WIN	IG_		09/18	8/2009
	ROVIDER OR SUPPLIER	LTH CARE INC	'	6	REET ADDRESS, CITY, STATE, ZIP CODE 501 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH COI		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 173	Patient #1 Patient #1 was admit including pressure uld of both lower extremi urinary incontinence at Patient #1's plan of coertification period of included wound care with NS (normal salin (lodosorb) cover with and tape." Patient #1's clinical renursing visit record (N documented, "Left for cleanser, pat dry, cov. On Patient #1's 9/12 documented, "clear cleanser, pat dry, left physician's order in the wound care. A NVR dated 9/16/08 regarding wound care. A NVR dated 9/16/08 regarding wound care. On 9/17/08, the nurse Physician's Orders/P "Weight monitoring NVRs in Patient #1's documented evidence 9/22/08 or 9/24/08. The patient weekly was not certification period of even though the patients.	ted on 8/1/08 with diagnoses cer of the great toe, edema ties, dementia, hypertension, and generalized weakness. are (POC) for the 8/1/08 through 9/29/08 orders which read, "Cleanse e), pat dry apply lodoserb 4X4 then secure with kerlix ecord contained a 9/9/08 NVR) on which the nurse of cleansed with wd (wound) vered with thin Tegasorb" //08 NVR the nurse insed with wd (wound) open to air" There was no me record to change the stacked any documentation in the to the left foot. et wrote on a Verification of lan of Care Update, once weekly"	G	173			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		297107	B. WING	S		09/1	8/2009
	ROVIDER OR SUPPLIER	ALTH CARE INC		601 WHT	DRESS, CITY, STATE, ZIP CODE TNEY RANCH, BLDG #D22 RSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 173	physician was awar weight, however, the on the NVR dated 1 Patient #1's plan of through 11/28/08 in (SN) frequencies of weeks and then one According to docum SN: saw Patient #1 week, did not see the saw the patient one two times a week for one week, did not eighth week, and saweek during the nin There was no docur clinical record indicate regarding the change to be provided. The Plan of Care Update frequency. Patient #3 Patient #3 Patient #3 Patient #3 was admediagnoses including aftercare for a fractic dependent diabetes. Patient #3's clinical order for the right here.	contained documentation the e of Patient #1's current e weight was not documented 2/2/08. care for the period 9/30/08 cluded orders for skilled nurse two times a week for six e time a week for three weeks. dentation in the clinical record, one time a week for one he patient the second week, time a week for three weeks, or one week, one time a week for three weeks, or one week, one time a week to see the patient during the law the patient two times a th week. The patient for three weeks, one time a week of see the patient during the law the patient two times a th week. The patient #1's lating SN notified the physician ges in the number of SN visits a clinical record did not have a let to change the SN visit Solitited on 6/15/09 with a pressure ulcer of the heel, ured tibia/fibula and insulin	G 1	73			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		297107	B. WING		09/1	8/2009
	ROVIDER OR SUPPLIER NS CHOICE HOME HEA	LTH CARE INC	6	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
G 173	Continued From page	e 48	G 173			
		10 different dated skilled nt heel wound was cleansed				
	The 7/17/09 physicia frequency for SN to v wound care two times	isit Patient #3 and provide				
	SN saw Patient #3 or 7/26/09. There was reclinical record to decrease for that week. There	ntation in the clinical record, ne time during the week of no physician's order in the rease the visits to one time was no physician's order to being used to clean the				
	profile (MP), Patient amg one by mouth every ceach nostril every dadosage noted) patch well as Lortab 7.5/50 every 4 hours; and C	of care and medication #3 was to take Protonix 40 ery day; Lasix 10 milligrams day; use Nasonex one spray y, apply a Lidoderm (no for 12 hours every day, as 0 milligram one by mouth oumadin 3 milligrams by y and 5 milligrams by mouth				
	- she no longer need	ernoon, Patient #3 indicated: led the Protonix and her she stopped taking it on				
	- the physician chan milligrams on 9/10/09					
	- she stopped using	the Nasonex on 7/4/09;				

1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297107	B. WING		09/	18/2009
	OVIDER OR SUPPLIER	LTH CARE INC	601	ET ADDRESS, CITY, STATE, ZIP CODE 1 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 173	on 6/15/09; - she was no longer 500 milligrams one ta was all she was takin - the physician presone by mouth every of taking it since 8/27/09 - she had been takin mouth every day since - she was taking Coumouth Monday through milligrams by mouth of the MP lacked docur regarding the change medications. There was updating the patient's Patient #3's Care Pla assistant (CNA) incluvisit; 2) change bed li observe fall precaution. Twenty-six of 26 CNA evidence the CNA per #3 with mouth care. documentation indicated of the communicated with the change the care plant.	taking Lortab and Tylenol ablet by mouth at bedtime g for pain; cribed Lisinopril 5 milligrams day and the patient had been 9; g a multivitamin one by the 3/13/09; and amadin 5 milligrams by gh Saturday and Coumadin 3 on Sundays since 9/8/09. The mented evidence of updates as made to Patient #3's was no physician's order as current medications. In for the certified nursing ded 1) mouth care every nens once a week; and 3) ons. A notes lacked documented arformed or assisted Patient There was no ting why the mouth care was each of the 26 visits. There in indicating the CNA ne nurse regarding the need	G 173			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	IG		09/1	8/2009
	ROVIDER OR SUPPLIER	LTH CARE INC		STREET ADDRESS, CITY, STATE, ZIP C 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
G 173	Six of 26 CNA notes indicating the CNA cl nails. The Care Plan nurse did not include care. There was no eskilled nurse modified accordance with the Patient #4 Patient #4 Patient #4 was admit diagnoses including a non-insulin depender hypertension. Patient #4's care plar nursing (SN) to see the for one week, one time and four visits as need the first week. There change the SN frequency patient #6 Patient #6 Patient #6 Patient #6 was admit including insulin dependency macular degeneration hypertension.	notes included ating the CNA observed fall oviding care to Patient #3. included documentation eaned/filed Patient #3's prepared by the registered instructions to provide nail documentation indicating the distructions to provide nail documentation indicating the distructions to provide nail documentation indicating the district the care plan in patient's preferences. Ited on 8/30/09 with abnormal gait, syncope, and diabetes mellitus and the patient two times a week are a week for eight weeks added for condition change. Items in Patient to time was no physician's order to encies.	G	173			

NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC SUMMANY STATEMENT OF DEPICIENCIES SUMMANY STATEMENT OF DEPICENCIES SUMMANY STATEMENT OF DEPICENCIES RECHARD FROM MUST BE PRECEDED BY FULL RECOURT WAST BE PRECEDED BY FULL RECOURT OWN LIST BE PRECEDED TO THE APPROPRIATE DEFICIENCY. G 173 Continued From page 51 period of 6/18/09 through 8/16/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record was missing 12 visits for this time frame. The clinical record lacked documentation indicating why each visit was missed. There was no physician's order to decrease the SN visits during this certification period of 8/17/09 through 10/15/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record was missing 9 visits for this time frame. The clinical record lacked documentation indicating why each visit was missed. The clinical record lacked a physician's order decreasing the SN visits during this certification period. Patient #7 Patient #7 Patient #7 Patient #7 was admitted on 8/26/09 with diagnoses including hypertension, generalized muscle weakness and dementia. Patient #7s plan of care included orders for skilled nursing (SN) to see the patient once a week for nine weeks. According to documents in Patient #7s clinical record lacked a physician's order to discontinue SN visits. Patient #8 Patient #8	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
PHYSICIANS CHOICE HOME HEALTH CARE INC CALL DESCRIPTION STATE STATE			297107	B. WIN	IG		09/1	8/2009
TAG TO Continued From page 51 period of 6/18/09 through 81/6/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record lacked documentation indicating why each visit was missed. There was no physician's order to decrease the SN visits during this certification period of 6/18/09 through 81/6/09 included orders to decrease the SN visits during this certification period. Patient #6's plan of care for the certification period of 8/17/09 through 10/15/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record was missing 9 visits for this time frame. The clinical record lacked documentation indicating why each visit was missed. The clinical record lacked documentation indicating why each visit was missed. The clinical record lacked a physician's order decreasing the SN visits during this certification period. Patient #7 Patient #7 Patient #7 was admitted on 8/26/09 with diagnoses including hypertension, generalized muscle weakness and dementia. Patient #7's plan of care included orders for skilled nursing (SN) to see the patient once a week for nine weeks. According to documents in Patient #7's clinical record. SN saw the patient one time. The clinical record lacked a physician's order to discontinue SN visits.			LTH CARE INC	•	6	01 WHTNEY RANCH, BLDG #D22	,	
period of 6/18/09 through 8/16/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record was missing 12 visits for this time frame. The clinical record lacked documentation indicating why each visit was missed. There was no physician's order to decrease the SN visits during this certification period. Patient #6's plan of care for the certification period of 8/17/09 through 10/15/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record was missing 9 visits for this time frame. The clinical record lacked documentation indicating why each visit was missed. The clinical record lacked a physician's order decreasing the SN visits during this certification period. Patient #7 Patient #7 was admitted on 8/26/09 with diagnoses including hypertension, generalized muscle weakness and dementia. Patient #7's plan of care included orders for skilled nursing (SN) to see the patient once a week for nine weeks. According to documents in Patient #7's clinical record, SN saw the patient one time. The clinical record lacked a physician's order to discontinue SN visits.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE		LD BE	COMPLETION
Patient #8 was admitted on 4/29/08 with diagnoses including insulin dependent diabetes mellitus, dementia, congestive heart failure and	G 173	period of 6/18/09 thro to be seen by skilled The clinical record wa time frame. The clinic documentation indica missed. There was n decrease the SN visit period. Patient #6's plan of ca period of 8/17/09 thro orders to be seen by day. The clinical reco this time frame. The documentation indica missed. The clinical order decreasing the certification period. Patient #7 Patient #7 was admitt diagnoses including h muscle weakness and Patient #7's plan of ca skilled nursing (SN) to week for nine weeks. According to docume record, SN saw the p record lacked a physi SN visits. Patient #8 Patient #8	augh 8/16/09 included orders nursing (SN) twice a day. as missing 12 visits for this cal record lacked ting why each visit was no physician's order to its during this certification are for the certification ough 10/15/09 included skilled nursing (SN) twice a ord was missing 9 visits for clinical record lacked iting why each visit was record lacked a physician's SN visits during this ted on 8/26/09 with hypertension, generalized dementia. are included orders for o see the patient once a certs in Patient #7's clinical atient one time. The clinical ician's order to discontinue ted on 4/29/08 with insulin dependent diabetes	G	173			

	(X3) DATE SURVEY COMPLETED	
297107 B. WING	09/1	8/2009
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC STREET ADDRESS, CITY, STATE, ZIP CO 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	•	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO T DEFICIENCY	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
legal blindness. Patient #8's plan of care included an update with a physician's order for skilled nursing (SN) to obtain vital signs one time a week. Patient #8's clinical record lacked documentation of vital signs the week of 6/28/09, 7/12/09 and 7/19/09. There was no physician's order cancelling the order to obtain vital signs once a week. Patient #10 Patient #10 Patient #10 Patient #10's plan of care for the buttock, failure to thrive, dementia, hypertension and urinary incontinence. Patient #10's plan of care for the certification period of 8/4/09 through 10/2/09 included orders for a certified nursing assistant (CNA) two times a week for nine weeks for personal care. The CNA saw Patient #10 one time during the first week of the certification period. The SN failed to make the necessary revisions to the plan of care regarding the CNA visit frequencies. On four visit notes, the CNA documented blood pressure readings of 156/104, 179/99, 184/99 and 198/88 for Patient #10. There was no documentation on the CNA or the SN notes indicating the CNA notified SN regarding the abnormally high blood pressure readings. The SN failed to notify the physician of the readings. Patient #11		

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		297107	B. WIN	G		09/1	8/2009
	NS CHOICE HOME HE	ALTH CARE INC		6	EET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 IENDERSON, NV 89014	, 33.1	5/ 2 000
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 173	diagnosis of chronic disease. Patient #11's plan of skilled nursing (SN) week." SN saw Patient #11 did not see the patient Falled to mathe plan of care regifrequencies. Patient #14 Patient #14 was addiagnoses including diabetes mellitus and skilled nursing (SN) week and then, one According to docum SN saw Patient #14 week, one time a withe patient for two with patient on 9/9/09 to The SN failed to mathe plan of care regifrequencies. Patient #15 Patient #15 Patient #15 was addiagnoses including diabetes mellitus are skilled nursing (SN) week and then, one skilled nursing (SN) week and then, one factor that the patient #14 week, one time a with patient for two with pa	mitted on 1/19/09 with a cobstructive pulmonary of care included orders for to see the patient "Q (every) one time the first week; then ent the second and third week, ake the necessary revisions to	G	173			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	IG		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•	STREET ADDRESS, CITY, STATE, ZIP COI 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 173	Continued From page	e 54	G	173	3		
	skilled nursing (SN) of week, two times a week one time a week for s	care included orders for one time a week for one ek for two weeks and then, six weeks.					
	did not see the patier the patient one time a	time a week for two weeks, at during the third week, saw a week for five weeks and patient during the last week riod (7/3/09 through					
		e the necessary revisions to rding the change in Patient ncies.					
	T	care included orders for a stant (CNA) two times a					
	CNA did not see Pati	clinical record revealed the ent #15 for the first two atient one time during the					
G 176	the plan of care regard #15's CNA visit frequ		G	176	6		
	, · · · ·	dinates services, informs the personnel of changes in the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297107	B. WIN	1G _		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•		REET ADDRESS, CITY, STATE, ZIP CODE 501 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THE DEFICIENCY)		D BE	(X5) COMPLETION DATE
G 176	Surveyor: 25418 Based on record revie ensure the registered physician of changes and 2) prepared clinic of 15 patients (Patient Findings include: Patient #1 Patient #1 was admit including pressure uld of both lower extremit urinary incontinence at visit record (NVR) day documentation reveateveloped a second of the was no documentation reveateveloped a second of the was no documentation. Patient #5 Patient #5 Patient #5 Patient #5 was admitt diagnoses including Federatia. On 5/27/09, the SN was morning visit documentation wound on the patient on 8/12/09, the eventage of the same and the patient of the same and the	ew, the agency failed to nurse 1) notified the in the conditions and needs; cal and progress notes for 6 ts #1, 5, 6, 9, 10, 15). Ited on 8/1/08 with diagnoses cer of the great toe, edema ties, dementia, hypertension, and generalized weakness. Eccord contained a nursing ted 10/2/08 which included ling the patient had wound on the left foot. Eentation indicating the nurse only sician regarding the new entry in the patient #5 for the need of the great the saw Patient #5 for the need discovery of a new	G	176			
			1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		297107	B. WING		00	/18/2009	
	OVIDER OR SUPPLIER		601	ET ADDRESS, CITY, STATE, ZIP CODE I WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014		716/2009	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 176	the SN who saw the the SN who saw the the SN who saw the the physician regard new findings. Patient #6 Patient #6 was admincluding insulin demacular degeneration hypertension. According to the introduced was depressed due died the previous with documentation in the nurse notified the plobtain a referral for emotional support. On nursing visit recentation of the nurse failed to was taught during the was taught during the was taught during the was experight lower lobe. Patient #6's clinical evidence the nurse	acked documented evidence e patient in the morning and e patient in the evening notified ding Patient #5's status and sitted on 3/1/07 with diagnoses bendent diabetes mellitus, on, legal blindness and sake assessment, Patient #6 to the fact that her spouse eek. There was no e clinical record indicating the hysician and attempted to a social work evaluation and ords (NVR) dated 8/28/09 at 12:00 PM, the nurse liabetes mellitus) teaching nderstanding"	G 176				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	G		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•	60	REET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 IENDERSON, NV 89014	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN C PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIEN		LD BE	(X5) COMPLETION DATE
G 176	certified nursing assist therapy (PT). Documentation in the the evaluation done to had "rash on butt." TSN was notified by Produced to documentation incomplysician regarding to Patient #10 Patient #10 Patient #10 was admediagnoses including patient to thrive, demonstrated to the transport of the patient #10 was seen assistant (CNA) two to care. The patient was (SN) once a week. On four visit notes, the pressure readings of and 198/88 for Patient	ted on 7/11/09 with heumatoid arthritis, ulcer and deep vein by skilled nursing (SN), stant (CNA) and physical area of skin condition on by PT revealed Patient #9 here was no documentation T of the rash and therefore, licating the nurse notified the he rash. Total on 6/5/09 with bressure ulcer of the buttock, entia, hypertension and hypertensi	G	176			
	indicating the CNA no abnormally high bloo	otified SN regarding the d pressure readings. The physician of the abnormally					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL				
		297107	B. WIN	G		09/1	8/2009
	OVIDER OR SUPPLIER NS CHOICE HOME HEA	LTH CARE INC		60	EET ADDRESS, CITY, STATE, ZIP CODE 11 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 176	An 8/5/09 nursing vis discovered a skin tearight arm. There was clinical record indicat physician of the skin 484.30(a) DUTIES ONURSE The registered nurse programs, and supernursing personnel. This STANDARD is Surveyor: 25418 Based on interview a agency failed to ensure participated in in-service supervised and taughter professional Services.	itted on 7/3/09 with nic obstructive pulmonary it record revealed the nurse of an odocumentation in the ing the nurse notified the tear. F THE REGISTERED participates in in-service vises and teaches other not met as evidenced by: Ind document review, the life the registered nurse vice programs and int other nursing personnel.		176	DEFICIENCY)		
	the in-services she had According to the ager	ncy's undated policy D-320 , "Regularly scheduled					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	IG _		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•		REET ADDRESS, CITY, STATE, ZIP CODE 501 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 178	employees"	e made available for all		178 215			
G 215	The home health aide hours of in-service traperiod. The in-service	PETENCY EVALUATION & e must receive at least 12 aining during each 12 month e training may be furnished shing care to the patient.	G	215			
	Surveyor: 25418 Based on record revieensure at least 12 ho	not met as evidenced by: ew, the agency failed to urs of in-service training per y 1 of 1 certified nursing					
G 229	was reviewed, was hi The CNA's personnel evidence of 12 hours for the past three yea 484.36(d)(2) SUPER' The registered nurse described in paragrap must make an on-site no less frequently tha	I file lacked documented of inservice training per year irs. VISION (or another professional oh (d)(1) of this section) e visit to the patient's home	G	229			
		ew and document review,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SUF COMPLET	
		297107	B. WIN	G		09/1	8/2009
	ROVIDER OR SUPPLIER	LTH CARE INC		601	ET ADDRESS, CITY, STATE, ZIP CODE WHTNEY RANCH, BLDG #D22 NDERSON, NV 89014	, 33.1	5/ 2 000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 229	the agency failed to eassistant supervisory registered nurse at lepatients (Patients #3, Findings include: Patient #3 Patient #3 was admit diagnoses including paftercare for a fractur dependent diabetes in Patient #3 had skilled therapy and certified services. A CNA supervisory v 7/20/09. The SN did 7/21/09. Patient #9 Patient #9 Patient #9 was admit diagnoses including in hypertension, peptic thrombosis. Patient #9 was seen physical therapy (PT) assistant (CNA). The documented evidence done by SN at least eassistant to the patient assistant to the patient a	ensure certified nursing visits were made by the east every 14 days for 4 of 15 of 9, 11, 15). Ited on 6/15/09 with pressure ulcer of the heel, red tibia/fibula and insulin mellitus. If nursing (SN), physical nursing assistant (CNA) isit for Patient #3 was due on the supervisory visit on	G	229			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		297107	B. WIN	IG		09/1	8/2009
	NS CHOICE HOME HEA	LTH CARE INC	•	6	REET ADDRESS, CITY, STATE, ZIP CODE 101 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 229	diagnosis of chronic disease. Patient #11 was see assistant (CNA) two two certification period at least every 14 ctimes. Patient #15 Patient #15 was admexacerbation of chrodisease. Patient #15's plan of certified nursing assistance. Supervisory visits of (SN) were due on 8/3 #15's clinical record of SN supervisory visits and 9/8/09. According to the age Home Health Aide Severy two (2) weeks	nitted on 1/19/09 with a obstructive pulmonary In by a certified nursing times a week. For the first ods, SN missed the deadline lays for a supervisory visit six witted on 7/3/09 with nic obstructive pulmonary care included orders for a stant (CNA) two times a	G	229	,		
G 236	current findings in ac professional standard patient receiving hon addition to the plan of	caining pertinent past and accordance with accepted as is maintained for every ne health services. In a force, the record contains a ginformation; name of	G	236			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLETI	
		297107	B. WIN	IG_		09/18	8/2009
	ROVIDER OR SUPPLIER	LTH CARE INC	•		REET ADDRESS, CITY, STATE, ZIP CODE 501 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 236	physician; drug, dieta orders; signed and da notes; copies of sumr attending physician; a	e 62 ary, treatment, and activity ated clinical and progress mary reports sent to the and a discharge summary.	G	236			
	the agency failed to e	ew and document review, ensure medical histories and was obtained from the of 15 patients (Patient #8, 14,					
	Findings include: Patient #8						
		ted on 4/29/08 with nsulin dependent diabetes ongestive heart failure and					
	Patient #14						
	_	itted on 8/11/09 with non-insulin dependent a fractured left shoulder.					
	Patient #15						
	Patient #15 was admi exacerbation of chron disease.	itted on 7/3/09 with nic obstructive pulmonary					
		5's clinical records lacked and physical. There was no					

Facility ID: NVS3767HHA

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SUI COMPLET	
		297107	B. WIN	G		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•	601	T ADDRESS, CITY, STATE, ZIP CODE WHTNEY RANCH, BLDG #D22 NDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 236	documents was mad According to the age	e indicating a request for the e to the referring physician. ncy's undated policy, C-140 ocess, "10. Past medical	G	236			
G 250	the program, review a closed clinical record	propriate health enting at least the scope of a sample of both active and s to determine whether are followed in furnishing	G	250			
	Surveyor: 25418 Based on documenta the agency failed to p review of clinical reco professionals, to dete policies were followe patients. Findings include: The Advisory Board I February 27, 2008, re clinical records was o was no documented clinical record audits documented evidence performed on clinical quarters of 2009.	records for the first two					
		ernoon, the Administrator s Director of Professional					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	E CONSTRUCTION	(X3) DATE SU COMPLE	
		297107	B. WIN	IG		09/1	18/2009
	OVIDER OR SUPPLIER	ALTH CARE INC		601	ET ADDRESS, CITY, STATE, ZIP CODE 1 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 250	and had to be dismis year, one of the regi the field to take the p On 9/15/09 in the af she knew exactly whout in the field but sl	not performing her duties ssed in January of this stered nurses came in from	G	250			
G 320	supposed to do in the 484.20 REPORTING HHAs must electron collected in accorda This CONDITION is Surveyor: 25418 Based on record rev	ne office. G OASIS INFORMATION ically report all OASIS data	G	320			
G 323	resulted in the failure assess the needs of 484.20(c)(1) TRANS The HHA must elect completed, encoded	tronically transmit accurate, I and locked OASIS data for State agency or CMS OASIS	G	323			
	Surveyor: 25418 Based on record rev failed to ensure com and locked OASIS of	riew and interview, the agency apleted, accurate, encoded lata was electronically monthly for 4 of 15 patients 15).					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION B	(X3) DATE SUF COMPLET	
		297107	B. WIN	G		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•	60	REET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 IENDERSON, NV 89014	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 323	evidence of OASIS co assessment forms for 9/9/09 through 11/7/0 On 9/17/09 in the after who was case manage paperwork had not be Patient #11 Patient #11 was admodiagnosis of chronic of disease. As of 9/18/09, Patient four certification period comprehensive recentionical record. Patient #13 Patient #13	ted on 7/11/09 with heumatoid arthritis, ulcer and deep vein the 49's clinical record lacked comprehensive recertification or the certification period of 199. The remoon, the registered nurse ging Patient #9 indicated the een submitted yet. The deep vein the certification period of 199. The remoon, the registered nurse ging Patient #9 indicated the een submitted yet. The remoon with a constructive pulmonary the 11 had been on service 1908. There were no OASIS tification assessments in the	G	3323	DEFICIENCY)		
	As of 9/18/09, Patient evidence of OASIS co	nce. t #13's clinical record lacked comprehensive recertification r the certification period of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		297107	B. WIN	IG_		09/1/	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	•	۱ (REET ADDRESS, CITY, STATE, ZIP CODE 501 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 323	Continued From page	e 66	G	323	3		
	Patient #15 Patient #15 was adm exacerbation of chror disease.	itted on 7/3/09 with nic obstructive pulmonary					
	evidence of OASIS of	t #15's clinical record lacked comprehensive recertification ertification period of 9/1/09					
		ents #9, 11, 13 and 15 came O (health maintenance					
	Professional Services referral source for the	ernoon, the Director of s (DPS) explained the e HMO patients recently eeded to complete admission S forms for the HMO					
G 330	had not been comple was not transmitted e	our HMO patients sampled ted and therefore, the data electronically. NSIVE ASSESSMENT OF	G	330			
	provide, a patient-spe assessment that accu current health status that may be used to o progress toward achi- outcomes. The comp must identify the patie home care and meet	urately reflects the patient's and includes information demonstrate the patient's evement of desired prehensive assessment ent's continuing need for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		297107	B. WIN	IG	 	09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC	'	6	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 332	HHA must verify the Medicare home healt homebound status, be assessment visit and comprehensive assessment must als current version of the Information Set (OAS language and groupin specified by the Secritory This CONDITION is Surveyor: 25418 Based on clinical receinterview, the agency admission to the age referral (G332); failed comprehensive assessment was using in order to adverse effects and clineffective drug thera significant drug interastherapy, and noncom (G337); and failed to assessment (G339). The cumulative effect resulted in the failure assess the needs of the patient's return to physician-ordered states.	Medicare beneficiaries, the patient's eligibility for the h benefit including oth at the time of the initial at the time of the ssment. The comprehensive or incorporate the use of the Outcome and Assessment (SIS) items, using the large of the OASIS items, as etary the most of the Oasis items, as etary the most of the oasis of the Oasis items, as etary the most of the oasis of the		330			
	IIIIS STAINDAND IS	not met as evidenced by:					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SUF	
			A. BUI	LDING			
		297107	B. WIN	IG		09/1	8/2009
	OVIDER OR SUPPLIER NS CHOICE HOME HEA	LTH CARE INC		60	EET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 332	agency failed to ensure was held within 48 held or on a specific date a or physician for 1 of 1 Findings include: Patient #7 Patient #7 was admitt diagnoses including huscle weakness and The referral for Patier agency on 8/21/09.	ord review and interview, the re an initial assessment visit ours of receipt of the referral as requested by the patient 5 patients (Patient #7). The ded on 8/26/09 with appertension, generalized didementia.	G	332			
G 337	done on 8/26/09. The reason for the delay. 484.55(c) DRUG REC. The comprehensive a review of all medication using in order to identificate and drug reaction drug therapy, significating interactions, dup noncompliance with compliance with complete the Surveyor: 25418. Based on record reviet the agency failed to eassessments of all more assessments of all more assessments.	ere was no documented GIMEN REVIEW assessment must include a cons the patient is currently tify any potential adverse tions, including ineffective ant side effects, significant olicate drug therapy, and drug therapy. The met as evidenced by: The wand document review, insure comprehensive edications were completed es were updated for 7 of 15	G	337			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		297107	B. WIN	IG_		09/1	8/2009
	OVIDER OR SUPPLIER	LTH CARE INC		'	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	1 00/1	0/2000
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 337	Continued From page	e 69	G	337	7		
	Findings include:						
	Patient #1						
	including pressure uld of both lower extremit urinary incontinence at the skilled nurse (SN visit record (NVR) dat was to have Triamcin her hands twice daily a physician's order for clinical record included (MP). Neither of the strength o	ted on 8/1/08 with diagnoses cer of the great toe, edema ties, dementia, hypertension, and generalized weakness. 1) documented on a nursing ted 11/5/08 that Patient #1 colone creme 1% applied to . The clinical record lacked r this medication. The ted two medication profiles two MPs in the clinical with Triamcinolone creme					
	Patient #1 was to have applied once a day. The NVR where on the to be applied. The cliphysician's order for the MPs in the clinical recording Patient #1 a regarding Clindamyci reactions, compliance The clinical record lace.	his medication. The two cord were not updated with 4%. 2/08, the SN documented and the caregiver " n use/purpose and adverse as per MD's ordered." cked a physician's order for 11/24/08 MP was not					
	Patient #3						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		297107	B. WING		09/	18/2009
	ROVIDER OR SUPPLIER	LTH CARE INC	6	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 337	aftercare for a fracture dependent diabetes in According to the plant profile (MP), Patient is mg one by mouth every deach nostril every da dosage noted) patch well as Lortab 7.5/50 every 4 hours; and C mouth every other da on the alternate days On 9/11/09 in the after the following: - she no longer need physician was aware 3/13/09; - the physician chang milligrams on 9/10/09 - she stopped using - the physician discoon 6/15/09; - she was no longer 500 milligrams one tawas all she was taking the physician presedures.	ted on 6/15/09 with bressure ulcer of the heel, ed tibia/fibula and insulin mellitus. of care and medication #3 was to take Protonix 40 ery day; Lasix 10 milligrams day; use Nasonex one spray y, apply a Lidoderm (no for 12 hours every day, as 0 milligram one by mouth oumadin 3 milligrams by and 5 milligrams by mouth of the Protonix and her she stopped taking it on ged the Lasix to 40 ery day; the Nasonex on 7/4/09; the Nasonex on 7/4/09; ntinued the Lidoderm patch taking Lortab and Tylenol ablet by mouth at bedtime g for pain; eribed Lisinopril 5 milligrams day and the patient had been	G 337			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
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	OVIDER OR SUPPLIER	LTH CARE INC	•	60	EET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 IENDERSON, NV 89014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 337	- she was taking Commouth Monday through milligrams by mouth the MP lacked document and the change medications. Patient #6 Patient #6 was admit including insulin dependent and the macular degeneration hypertension. Patient #6's Medication 12/19/08 and "update 6/17/09, indicated the milligrams every day milligrams sometime noted). Patient #6's clinical retitled "Protime/INR Reduced and the information and the informatio	g a multivitamin one by the 3/13/09; and sumadin 5 milligrams by gh Saturday and Coumadin 3 on Sundays since 9/8/09. Interest of updates are made to Patient #3's sumade to Profile (MP) dated and sumadin 4 suntil it was changed to 3 in June 2009 (exact date not second included a document esults" dated 8/14/09. The sumadin 2 milligrams by 4/09. In a dated 9/9/09 in Patient #6's sed an INR result of 1.0. In the pumadin 2 milligrams by an ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the sumadin 2 milligrams by the ordered the Coumadin to the ordered the coumadin 2 milligrams the ordered the coumadin 2 milligrams the ordere	G	337			
	be increased to 4 mil	ligrams by mouth every day.					

PRINTED: 10/21/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING				
		297107	B. WING		09/1	3/2009
	OVIDER OR SUPPLIER NS CHOICE HOME HEA	LTH CARE INC	6	REET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE
G 337	Continued From page	e 72	G 337			
	lacked documented e being updated to refle by mouth daily as of S According to the 7/8/0 Patient #6's clinical re milligrams one by mo discontinued and the Sucralfate one grams Patient #6's MP was reflect the discontinua	8/16/09 through 10/14/09) evidence of this medication ect Coumadin 4 milligrams 8/9/09. Description of the county				
	Sucralfate. Patient #7					
	Patient #7 was admitt diagnoses including h muscle weakness and	nypertension, generalized				
	_	ication administration record sisted living facility where e patient:				
	by mouth three times	500 milligrams two tablets a day (as of 8/27/09) and as listed on the medication nical record);				
		op solutions beginning on ays prior to eye surgery (not				
		0 milligrams one tablet by e 9/2/09 (not listed on MP);				

Facility ID: NVS3767HHA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297107			[` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED 09/18/2009	
		B. WIN	G				
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC			•	60	EET ADDRESS, CITY, STATE, ZIP CODE 01 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)		LD BE	(X5) COMPLETION DATE
G 337	Continued From page	e 73	G	337			
	day as needed for all	one tablet by mouth every ergies (not listed on MP).					
	Patient #8						
		ted on 4/29/08 with nsulin dependent diabetes ongestive heart failure and					
	updated to reflect the medications (taking N Magnesia, Hydrocort taking Lisinopril, Sero	on profile (MP) was not changes in the patient's Novolin insulin, Milk of isone 1% cream, Coreg; not oquel) as listed on the ation record kept by the ent resided.					
	Patient #9						
	Patient #9 was admit diagnoses including r hypertension, peptic vein thrombosis.						
	care facility for treatment the leg. The patient v						
	Patient #9's clinical re	visit records (NVR) in ecord, SN administered ubcutaneously every day 0/13/09.					
	Patient #9's clinical re	ecord lacked a physician's					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
297107		B. WIN	1G		09/18/2009		
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC				601 WHTNEY RANCH, BLDG #D22			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION		ILD BE	(X5) COMPLETION DATE	
order for Arixtra. The updated to include Ar Patient #11 Patient #11 was adm diagnoses chronic ob Patient #11 was read discharged back hom certification periods. ordered upon dischar not noted on the med According to the ager Medication Profile, " documentation of the of all medications the and identify discreparand the physician and 484.55(d)(1) UPDATI COMPREHENSIVE AT The comprehensive a updated and revised of the OASIS) the last beginning with the statis a beneficiary elected change in condition massessment; or disched the CASIS of the CA	itted on 1/19/09 with structive pulmonary disease. mitted to the hospital and le three times during four The medication changes age from the hospital were lication profile. Incy's undated policy C-700 and Purpose and Top provide comprehensive assessment patient is currently taking, incies between patient profile and profile. E OF THE ASSESSMENT Assessment must be (including the administration at 5 days of every 60 days and of care date, unless there are detailed to the same and return to the same and return to the same and representation.						
Based on record revi	ew, document review and						
	SUMMARY ST. (EACH DEFICIENCY REGULATORY OR I Continued From page order for Arixtra. The updated to include Ar Patient #11 Patient #11 was adm diagnoses chronic ob Patient #11 was read discharged back homoertification periods. ordered upon dischar not noted on the med According to the ager Medication Profile, " documentation of the of all medications the and identify discreparand the physician and 484.55(d)(1) UPDATE COMPREHENSIVE AT The comprehensive a updated and revised of the OASIS) the las beginning with the statis a beneficiary electer change in condition reassessment; or disch HHA during the 60 da This STANDARD is a Surveyor: 25418	OVIDER OR SUPPLIER NS CHOICE HOME HEALTH CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 order for Arixtra. The medication profile was not updated to include Arixtra. Patient #11 Patient #11 was admitted on 1/19/09 with diagnoses chronic obstructive pulmonary disease. Patient #11 was readmitted to the hospital and discharged back home three times during four certification periods. The medication changes ordered upon discharge from the hospital were not noted on the medication profile. According to the agency's undated policy C-700 Medication Profile, " Purpose To provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile 484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by:	OVIDER OR SUPPLIER NS CHOICE HOME HEALTH CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 order for Arixtra. The medication profile was not updated to include Arixtra. Patient #11 Patient #11 was admitted on 1/19/09 with diagnoses chronic obstructive pulmonary disease. Patient #11 was readmitted to the hospital and discharged back home three times during four certification periods. The medication changes ordered upon discharge from the hospital were not noted on the medication profile. According to the agency's undated policy C-700 Medication Profile, " Purpose To provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile 484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Surveyor: 25418	OVIDER OR SUPPLIER NS CHOICE HOME HEALTH CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 order for Arixtra. The medication profile was not updated to include Arixtra. Patient #11 Patient #11 Patient #11 was admitted on 1/19/09 with diagnoses chronic obstructive pulmonary disease. Patient #11 was readmitted to the hospital and discharged back home three times during four certification periods. The medication changes ordered upon discharge from the hospital were not noted on the medication profile. According to the agency's undated policy C-700 Medication Profile, " Purpose To provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile 484.55(a)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Surveyor: 25418	OVIDER OR SUPPLIER NS CHOICE HOME HEALTH CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REQUIATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 Co	COMPLET 297107 STREET ADDRESS, CITY, STATE, ZIP CODE 80 WITHING YRANCH, BLDG #D022 HENDERSON, NV 89014 SUMMARY STATEMENT OF DEPOLENCIES (EACH DEPOLEMENCE) (EACH	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		297107	B. WING			09/18/2009		
	ROVIDER OR SUPPLIER	LTH CARE INC	'	60	EET ADDRESS, CITY, STATE, ZIP CODE D1 WHTNEY RANCH, BLDG #D22 ENDERSON, NV 89014	, 00/10	5/ 2 000	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
G 339	interview, the agency comprehensive asses during the last five da beginning with the stapatients (Patients #1, Findings include: Patient #1 Patient #1 was admit including pressure ulder of both lower extremit urinary incontinence at Patient #1's clinical refrecertification compre 9/24/08. The certification compre 9/24/08. The certification through 9/29/05 the comprehensive as 9/25/08 through 9/29/05 assessment was don Patient #3 Patient #3 was admitt diagnoses including paftercare for a fracture dependent diabetes in As of 9/18/09, Patient documented evidence comprehensive assess period of 8/14/09 through 9/18/09, Patient As of 9/18	failed to ensure system of every 60 days art of care date for 6 of 15 a, 9, 11, 13, 15). Ited on 8/1/08 with diagnoses cer of the great toe, edema ties, dementia, hypertension, and generalized weakness. Ecord contained a shensive assessment dated ation period at that time was 18. The five day window for essessment to be done was 1/08. The comprehensive e one day early. Ited on 6/15/09 with pressure ulcer of the heel, ed tibia/fibula and insulin mellitus. It #3's clinical record lacked the of a recertification essment for the certification essment for the certification essment for the certification.	G	339				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		297107	B. WIN	1G _		09/18	3/2009
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC					REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORP PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY)		.D BE	(X5) COMPLETION DATE
G 339	who was case manage paperwork had not be No OASIS (Outcome Information Set) form last five days of Patie period. Therefore, no was generated for the 9/9/09 through 11/8/0 Patient #11 Patient #11 Patient #11 was adm diagnoses chronic ob As of 9/18/09, Patient four certification perior recertification comprescionical record. As of 9/18/09, there worders in the clinical recurrent certification perior current certification current certification current certification current certification current certification current certification cu	ted on 7/11/09 with heumatoid arthritis, ulcer and deep vein ernoon, the registered nurse ging Patient #9 indicated the een submitted yet. and Assessment s were completed during the nt #9 's initial certification of plan of care (with orders) e certification period from 19. itted on 1/19/09 with structive pulmonary disease. If #11 had been on service of the ensive assessments in the evas no plan of care with ecord for Patient #11 for the eriod. and Assessment s were completed during the entital certification period for re, no plan of care (with d for the current certification	G	339			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297107		` '			(X3) DATE SURVEY COMPLETED	
		B. WIN	IG		09/18/2009	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC			6	01 WHTNEY RANCH, BLDG #D22	,	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	PREFIX (EACH CORRECTIVE ACTION		LD BE	(X5) COMPLETION DATE
Patient #13 Patient #13 was adm diagnoses including i mellitus and urinary i Ms of 9/18/09, Patient documented evidence comprehensive asseperiod of 9/20/09 throws the five days of the in Patient #13. Therefore orders) was generate period of 9/20/09 throws was generated period of 9/20/09 throws was generated period of 9/20/09 throws was generated period of 9/20/09 throws was admended evidence comprehensive asseperiod of 9/1/09 throws plan of care with order patient #15 for the current with the generation of care and no OASIS these patients. According to the age	itted on 7/22/09 with insulin dependent diabetes incontinence. It #13's clinical record lacked to of a recertification insulin 11/18/09. In and Assessment to severe completed during the initial certification period for order, no plan of care (with the difference of a recertification period for order, no plan of care (with the difference of a recertification or order). It #15's clinical record lacked to of a recertification insulin 10/30/09. There was no ordered in the clinical record for order order order of a recertification period. It review the plans of care for order of the certification of the plan is forms were completed for oncy's undated policy, C-480	G	339			
	COVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page Patient #13 Patient #13 was adm diagnoses including i mellitus and urinary i As of 9/18/09, Patien documented evidence comprehensive asse period of 9/20/09 thro No OASIS (Outcome Information Set) form last five days of the in Patient #13. Therefor orders) was generate period of 9/20/09 thro Patient #15 As of 9/18/09, Patien documented evidence comprehensive asse period of 9/1/09 thro plan of care with orde Patient #15 for the cu The physician did no Patients # 9, 11, 13 a drives the generation of care and no OASIS these patients. According to the age	CORRECTION DENTIFICATION NUMBER: 297107 COVIDER OR SUPPLIER NS CHOICE HOME HEALTH CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 77 Patient #13 Patient #13 was admitted on 7/22/09 with diagnoses including insulin dependent diabetes mellitus and urinary incontinence. As of 9/18/09, Patient #13's clinical record lacked documented evidence of a recertification comprehensive assessment for the certification period of 9/20/09 through 11/18/09. No OASIS (Outcome and Assessment Information Set) forms were completed during the last five days of the initial certification period for Patient #13. Therefore, no plan of care (with orders) was generated for the current certification period of 9/20/09 through 11/18/09. Patient #15 Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease. As of 9/18/09, Patient #15's clinical record lacked documented evidence of a recertification comprehensive assessment for the certification period of 9/1/09 through 10/30/09. There was no plan of care with orders in the clinical record for Patient #15 for the current certification period. The physician did not review the plans of care for Patients # 9, 11, 13 and 15 since the OASIS drives the generation and preparation of the plan of care and no OASIS forms were completed for	A BUIL 297107 B WINDER OR SUPPLIER NS CHOICE HOME HEALTH CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 77 Patient #13 Patient #13 was admitted on 7/22/09 with diagnoses including insulin dependent diabetes mellitus and urinary incontinence. As of 9/18/09, Patient #13's clinical record lacked documented evidence of a recertification comprehensive assessment for the certification period of 9/20/09 through 11/18/09. No OASIS (Outcome and Assessment Information Set) forms were completed during the last five days of the initial certification period for Patient #13. Therefore, no plan of care (with orders) was generated for the current certification period of 9/20/09 through 11/18/09. Patient #15 Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease. As of 9/18/09, Patient #15's clinical record lacked documented evidence of a recertification comprehensive assessment for the certification period of 9/1/09 through 10/30/09. There was no plan of care with orders in the clinical record for Patient #15 for the current certification period. The physician did not review the plans of care for Patients #9, 11, 13 and 15 since the OASIS drives the generation and preparation of the plan of care and no OASIS forms were completed for these patients. According to the agency's undated policy, C-480	A BUILDING 297107 A BUILDING B. WING 297107 A BUILDING B. WING COVIDER OR SUPPLIER NS CHOICE HOME HEALTH CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 77 Patient #13 Patient #13 was admitted on 7/22/09 with diagnoses including insulin dependent diabetes mellitus and urinary incontinence. As of 9/18/09, Patient #13's clinical record lacked documented evidence of a recertification comprehensive assessment for the certification period of 9/20/09 through 11/18/09. No OASIS (Outcome and Assessment Information Set) forms were completed during the last five days of the initial certification period for Patient #13. Therefore, no plan of care (with orders) was generated for the current certification period of 9/20/09 through 11/18/09. Patient #15 Patient #15 Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease. As of 9/18/09, Patient #15's clinical record lacked documented evidence of a recertification comprehensive assessment for the certification period of 9/1/09 through 10/30/09. There was no plan of care with orders in the clinical record for Patient #15 for the current certification period. The physician did not review the plans of care for Patients # 9, 11, 13 and 15 since the OASIS drives the generation and preparation of the plan of care and no OASIS forms were completed for these patients. According to the agency's undated policy, C-480	COVIDER OR SUPPLIER NS CHOICE HOME HEALTH CARE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 77 Patient #13 Patient #13 was admitted on 7/22/09 with diagnoses including insulin dependent diabetes mellitus and urinary incontinence. As of 9/18/09, Patient #13's clinical record lacked documented evidence of a recertification period of 9/20/09 through 11/18/09. Patient #15. Therefore, no plan of care (with orders) was generated for the current certification period of 9/20/09 through 11/18/09. Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease. As of 9/18/09, Patient #15's clinical record lacked documented evidence of a recertification period of 9/20/09 through 11/18/09. Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease. As of 9/18/09, Patient #15's clinical record lacked documented evidence of a recertification period of 9/20/09 through 10/30/09. There was no plan of care with orders in the clinical record for patient #15 for the current certification period of 9/10/09 through 10/30/09. There was no plan of care with orders in the clinical record for Patient #15 for the current certification period of 9/1/09 through 10/30/09. There was no plan of care with orders in the clinical record for Patients #15 for the current certification period. The physician did not review the plans of care for Patients #15, 11, 13 and 15 since the OASIS drives the generation and preparation of the plan of care and no OASIS forms were completed for these patients. According to the agency's undated policy, C-480	CONFIGER OR SUPPLIER 297107 STREET ADDRESS, CITY, STATE, ZIP CODE 601 WITNEY RANCH, BLOG 8022 HENDERSON, NV 89014 SUMMARY STATEMENT OF DEFICIENCES (FACH DEFICIENCY MUST BE PRECEDED BY FUIL, RESULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (FACH OBJOINT) COntinued From page 77 Patient #13 Patient #13 was admitted on 7/22/09 with diagnoses including insulin dependent diabetes mellitus and unirary incontinence. As of 9/18/09, Patient #13's clinical record lacked documented evidence of a recertification period of 9/2009 through 11/18/09. No OASIS (Outcome and Assessment Information Set) forms were completed during the last five days of the initial certification period of 9/2009 through 11/18/09. Patient #15 Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease. As of 9/18/09, Patient #15's clinical record lacked documented evidence of a recertification period of 9/2009 through 11/18/09. Patient #15 Patient #15 for the current certification period of 9/1/09 through 10/30/09. There was no plan of care with orders in the clinical record for Patient #15 for the current certification period of 9/1/09 through 10/30/09. There was no plan of care with orders in the clinical record for Patient #15 for the current certification period of 9/1/09 through 10/30/09. There was no plan of care with orders in the clinical record for Patient #15 for the current certification period of 9/1/09 through 10/30/09. There was no plan of care and no OASIS forms were completed for these patients. According to the agency's undated policy, C-480

1 ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297107	B. WING			09/18/2009	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC			,	•	REET ADDRESS, CITY, STATE, ZIP CODE 501 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014		5. 2 000
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY)		LD BE	(X5) COMPLETION DATE
G 340	as the severity of the but at least one time of According to the ager Patient Reassessmer Assessment, " Rea at least: 1. Every se beginning with start of forty-eight (48) hours return home from hos than twenty-four (24) than diagnostic testin On 9/17/09 in the after professional services told by the Medicare organization) referral complete the OASIS and the final discharge 13 and 15). 484.55(d)(2) UPDATE COMPREHENSIVE ATTHE COMPREHENSIVE	tending physician as often client's condition requires, every 60 days" Incy's undated policy, C-155 at/Update of Comprehensive assessments must be done cond calendar month of care 2. Within of (or knowledge of) patient spital admission of more hours for any reason other g" Incy's undated policy, C-155 at/Update of Comprehensive assessments must be done cond calendar month of care 2. Within of (or knowledge of) patient spital admission of more hours for any reason other g" Incy's undated policy, C-155 at/Update of Comprehensive assessments must be done conditionally admission of any reason other than a hospital admission of any reason other than assessment including completion assessment including completion assessment Information Set		340			
	(OASIS) was complete	ted within 48 hours of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297107			(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WIN	IG		09/18/2009			
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC				6	REET ADDRESS, CITY, STATE, ZIP CODE 601 WHTNEY RANCH, BLDG #D22 HENDERSON, NV 89014			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN (PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED TO DEFICIE		CTION SHOULD BE O THE APPROPRIATE		
G 340	longer than 24 hours #9, 11). Findings include: Patient #9 Patient #9 was admit diagnoses including rhypertension, peptic thrombosis. According to docume clinical record, the pathospital on 8/21/09 a on 8/25/09. As of 9/16/09, the clindocumented evidence comprehensive asseriation asseriation of chrordisease. The plan of skilled nursing (SN) a assistant (CNA). Patient #11 was admit 2/3/09 and discharge the patient on 2/8/09. comprehensive resurdated 2/8/09 in the patient #11 was admit 2/8	ted on 7/11/09 with heumatoid arthritis, ulcer and deep vein ntation in Patient #9's tient was transferred to a nd discharged back home nical record lacked a resumption of care as resumption of care as ment was done after ome on 8/25/09. itted on 1/19/09 with nic obstructive pulmonary care included orders for and certified nursing itted to the hospital on d home on 2/7/09. SN saw	G	340				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING					
		297107	B. WING	B. WING		/18/2009	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC			601	T ADDRESS, CITY, STATE, ZIP CODE WHTNEY RANCH, BLDG #D22 NDERSON, NV 89014	•		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
G 340	the patient on 5/14/09 comprehensive resurdated 5/14/09 in the patient #11 was adm 6/24/09 and discharg saw the patient on 6/2 comprehensive resurdated 6/3/09 in the patient Reassessment Assessment, " Reat least: 1. Every se beginning with start of forty-eight (48) hours return home from hos than twenty-four (24) than diagnostic testin On 9/17/09 in the after professional services told by the Medicare organization) referral complete OASIS(the Information Set) com	9. There was no inption of care assessment patient's clinical record. iitted to the hospital on ed home on 6/29/09. SN 30/09. There was no inption of care assessment atient's clinical record. Incy's undated policy, C-155 int/Update of Comprehensive assessments must be done cond calendar month of care 2. Within of (or knowledge of) patient spital admission of more hours for any reason other	G 340				